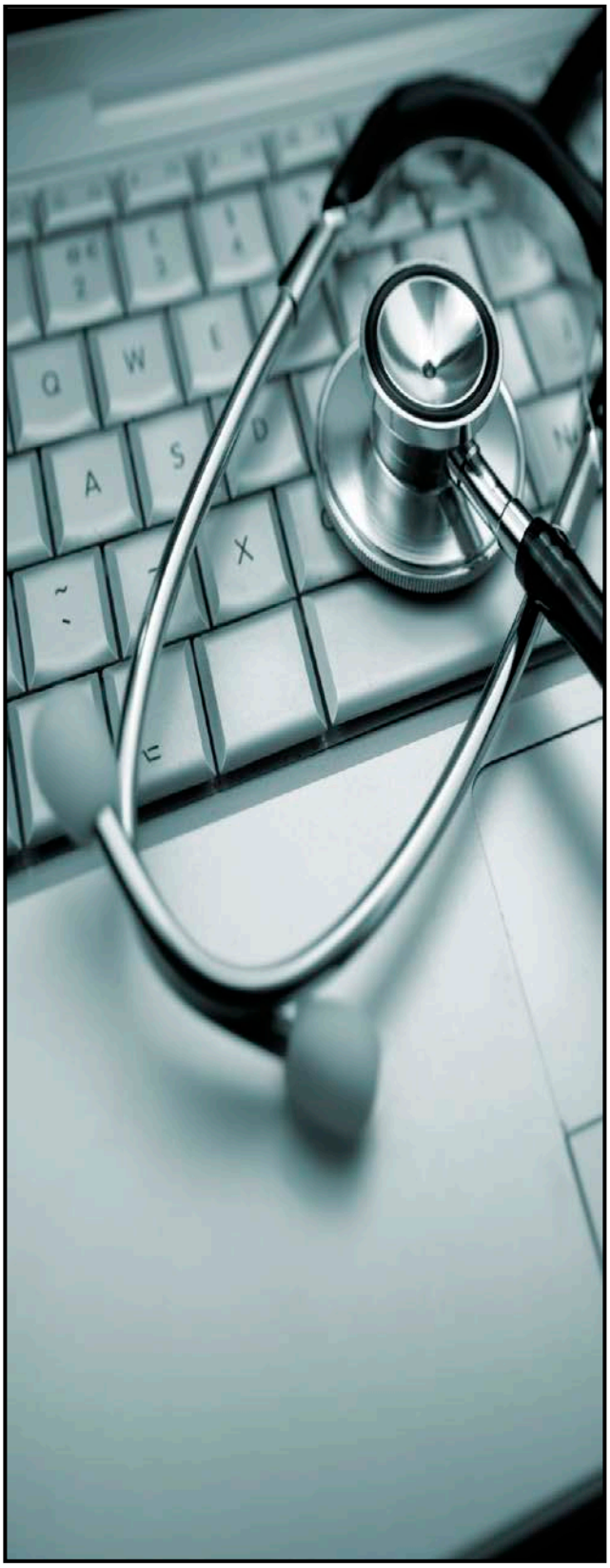

*e*CLINICIAN – EMR

User Guide

The contents of this User Guide reflect version 2012.

Alberta Health Services

Updated: 10 February 2015

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This guide does not contain documentation pertaining to specialty specific workflows.

Please refer to the *e*CLINICIAN-EMR Training Documents web page for this information.

WELCOME

A MESSAGE FROM DR. TIM GRAHAM

Welcome to the ***e*CLINICIAN - EMR** User Guide!

***e*CLINICIAN** is Alberta Health Services' branding of Epic Systems' Epicare Ambulatory Electronic Medical Record (EMR). As of September 2012, approximately 500 physicians, nurses, nurse practitioners, pharmacists, and over 2000 administrative users are contributing health information to the ***e*CLINICIAN** database in the Edmonton zone.

Using an EMR for the first time, or transitioning from one EMR to another, can be a challenge. In addition to adopting ***e*CLINICIAN**, your clinic will also go through workflow changes that are intended to make things more efficient and patient-centric in the long run. In the early days some productivity loss is inevitable with such a big transition, and we would advise you to adjust your schedule, based on the recommendations of the ***e*CLINICIAN** project team. It can take several months to become proficient in using ***e*CLINICIAN**, and while it may initially seem complicated, we have found that users appreciate the depth of capability that the product provides, in the long run. Peer support is critical during these early phases, and if you find yourself struggling, do not be afraid to ask for help. Similarly, we encourage you to help your colleagues when you are able to do so.

In order to meet its clinical and strategic goals, the Edmonton Zone has also chosen Epic's software for inpatient facilities. This will allow patient-centric data such as medications, allergies, care plans etc., to be seamlessly shared between inpatient and ambulatory environments. Epic also has modules for mobile devices (iOS and Android), and to enable remote electronic communication and delivery of health information between patients and clinicians. There will be many opportunities to leverage these and other exciting modules in the Epic suite of products, to help provide and guide clinical care transformation in the future.

There is ample opportunity for you to get more involved with ***e*CLINICIAN** if you are interested. There are a number of governance committees which are chaired and led by clinicians and guide the project roll-out to new clinics, govern live clinics, prioritize new features and requests for extra functionality, and oversee things such as data stewardship and research. Each clinical program should also have a clinical lead who will try to troubleshoot your questions locally and help optimize the EMR for your clinic.

Above all, try to keep a sense of humour as you go through training and go-live; a little humour will go a long way on this road to optimizing patient outcomes!

DR. TIM GRAHAM,

SENIOR MEDICAL DIRECTOR OF CLINICAL INFORMATICS,
NORTH ALBERTA HEALTH SERVICES

INTRODUCTION

***e*CLINICIAN - Electronic Medical Record (EMR)** is Alberta Health Services' integrated clinical system providing a single patient electronic medical record for ambulatory care.

This User Guide is a supplement to the ***e*CLINICIAN - EMR** classroom training programs. It includes steps for the tasks you perform frequently, such as entering orders and writing notes. Steps that you perform less frequently are also listed in this guide. The guide is also a valuable source of tips to help you optimize your use of ***e*CLINICIAN**.

USING THIS GUIDE

Each topic in the guide is constructed as an independent unit. You can read the guide from start to finish or seek out a topic of interest.

Features of the guide include:

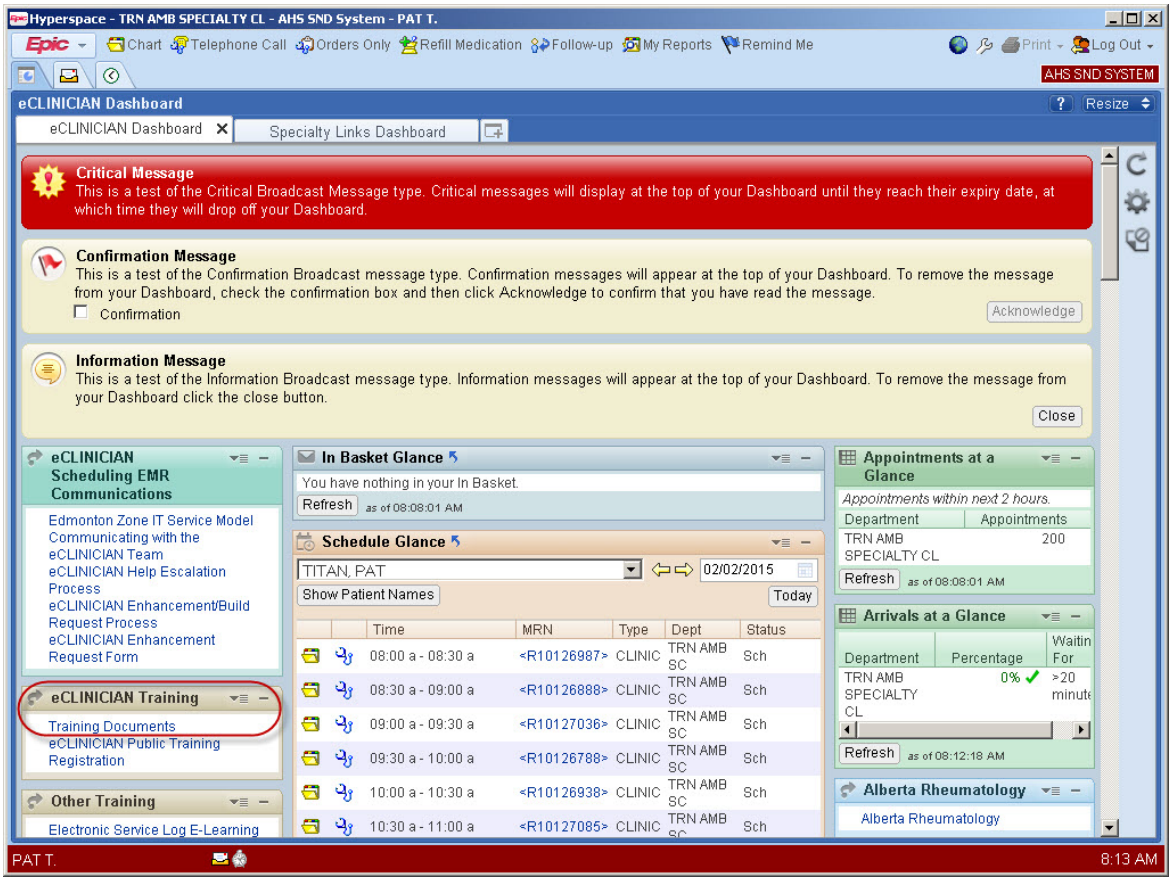
- Organization based on the flow of a typical visit.
- **TIPS** highlight important information and offer suggestions to help you optimize your use of ***e*CLINICIAN**.
- Personalization topics present steps to help you customize ***e*CLINICIAN** to meet your needs.
- Appendices include resources that you can print and keep at your desk for easy reference.

In addition to the **TIPS** flagged throughout this guide, look for the following indicators:

	Indicates additional information about the item or topic
	Indicates Critical Information
	Indicates a time saving technique
	Indicates a best practice for using a shared EMR

ADDITIONAL RESOURCES

Additional ***e*CLINICIAN - EMR** training documents and resources are available online. Click the Training Materials link in the ***e*CLINICIAN** Training information box on your ***e*CLINICIAN** Home workspace. You will be taken to the Alberta Health Services Insite Training Documents page with a link to EMR documents.



Alternatively, when connected to the Alberta Health Services network, you can access the Insite page directly using this link:

http://insite.albertahealthservices.ca/11520.asp

> **TIP**: Be sure to check this site regularly for new and updated documents.

If you have questions, comments, or suggestions about our documentation, send us an e-mail at iseCLINICIANTrainingRequests@albertahealthservices.ca. We appreciate your feedback!

eCLINICIAN FUNDAMENTALS

This chapter describes the general look and feel of ***e*CLINICIAN - EMR** as well as basic navigation techniques. You'll also be introduced to an important set of documentation tools called SmartTools.

The following main topics are covered in this chapter:

- Access ***e*CLINICIAN**
- Review Parts of Hyperspace
- Use SmartTools

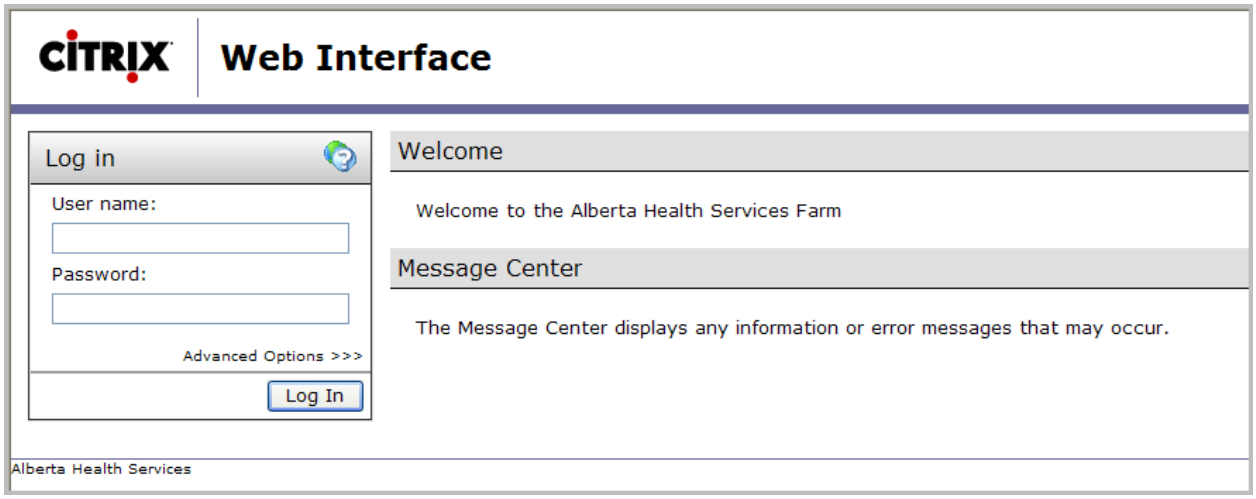
ACCESS eCLINICIAN

The following topics show you how to access ***e*CLINICIAN** and how to log in and out of ***e*CLINICIAN**.

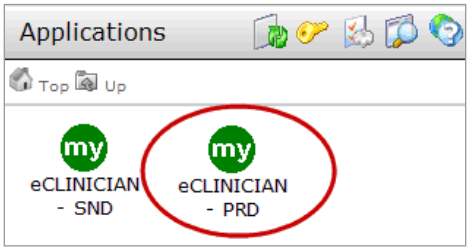
LOG IN TO CITRIX

Think of the Citrix application as being the ***gateway*** to ***e*CLINICIAN**.

1. Log on to your computer.
2. Access Citrix in one of the following two ways:
   - For users on the Alberta Health Services network, select **Start Menu > Clinical Applications > *e*CLINICIAN**.
   - For users not on the Alberta Health Services network, access Citrix via the method set up for your clinic.



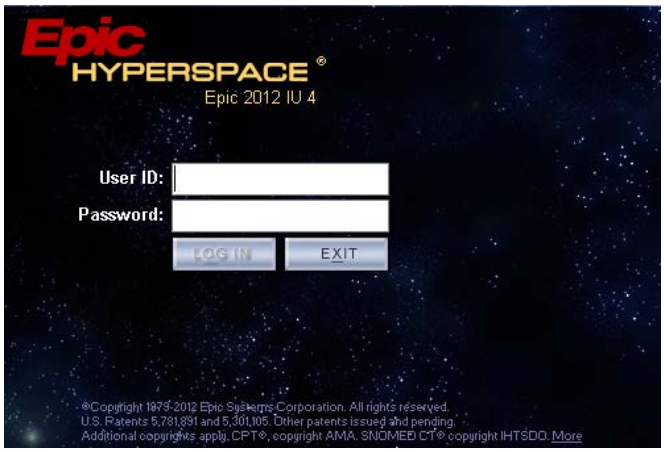
3. From the Citrix Web Interface screen, type your Alberta Health Services (AHS) user name and password. Various ***e*CLINICIAN** icons display based on your user role.
4. To launch ***e*CLINICIAN**, click the ***e*CLINICIAN PRD** icon.



LOG IN TO HYPERSPACE

Hyperspace is the name given to the architecture that hosts all of Epic's applications. Epic Systems is the software vendor for ***e*CLINICIAN**. Think of Hyperspace as the ***face*** of ***e*CLINICIAN**.

5. In the **User ID** field in the Hyperspace login window, type your Alberta Health Services user name.


Epic
HYPERSPACE
Epic 2012 IU 4
User ID:
Password:
LOG IN
EXIT
©Copyright 1979-2012 Epic Systems Corporation. All rights reserved.
U.S. Patents 5,781,891 and 5,301,105. Other patents issued and pending.
Additional copyrights apply. CPT®, copyright AMA. SNOMED CT®, copyright IHTSDO. More

6. In the **Password** field, type your Alberta Health Services password.
7. Click **Log In** or press **ENTER**. The Department selection screen displays.
8. To log in, do one of the following:
   A. If your clinic (department) displays by default, click **OK** or press **ENTER**.
   B. To select a clinic other than the one that displays by default, or if no clinic is displayed, click the **Selection** Tool (magnifying glass). The Record Select window displays.
      i. Select the name of the clinic from the Recent tab.
      ii. If no clinics display on the Recent tab (or if the clinic you wish to log into is not on this tab), select the Search tab.
         - Type the name of the department starting with the site or service abbreviation (i.e. UAH, UAH KEC, RAH, GRH, AMH, CHS, etc.).
         - To see a list of clinics that match your search criteria, click the **Selection** Tool again.
         - Select the appropriate clinic from the list and click **Accept**. The Department selection screen re-displays.
      iii. To log into the clinic (department), click **OK** or press **ENTER**.

Your ***e*CLINICIAN** Dashboard (formerly known as the Homepage) displays.

LOG OUT OF HYPERSPACE

To maintain patient confidentiality, you must log out or secure your computer when you are done working or have to leave the computer for any reason.

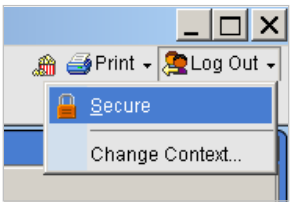
To ***log out*** of ***e*CLINICIAN**, from the Hyperspace toolbar, click

.

To s***ecure*** your workstation, from the Hyperspace toolbar either:

- Click

, if available, or
- Next the **Log Out** button, click the arrow and then click **Secure**.



The availability of the **Secure** button from the Hyperspace toolbar is dependent on your user permissions.

When you secure a workstation, Hyperspace remembers where you are so that you, or the next user to log in with similar EMR security, sees the same thing.

When a computer has been secured, a notification message displays on the login screen, as shown below.

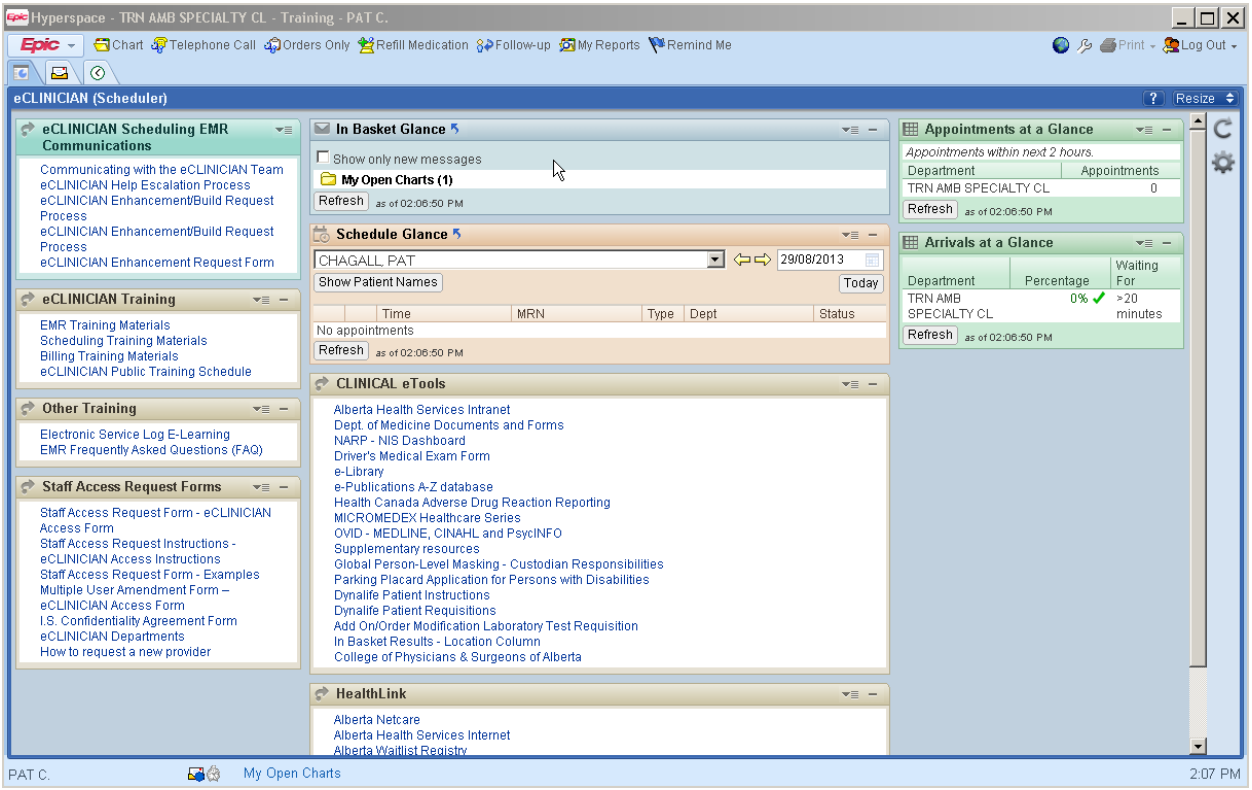
You can also Log Out and Secure from the **Epic** button menu options.

REVIEW PARTS OF HYPERSPACE

This section provides you with a quick review of the main Hyperspace components.

THE DASHBOARD

When you first log in to ***e*CLINICIAN** the ***e*CLINICIAN** Dashboard displays. The Dashboard is your Home workspace. The Dashboard displays each time you log in and is the hub for all your activities. From here you can quickly check for In Basket messages, see if patients have arrived for their appointments and access a number of useful links and etools.



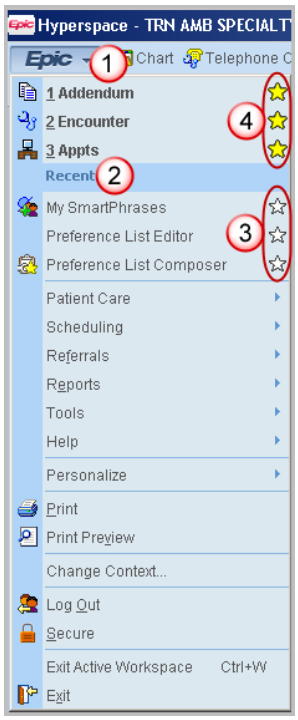
TITLE BAR

The Title bar displays the names of the following:

- Application
- Department you are logged in to
- Environment
- The logged on user. Your user name displays as your first name and the first initial of your last name.

EPIC BUTTON

In order to provide you with more working space, many of the secondary features you need are available from the **Epic** button.



① To open the Epic menu, click the **Epic** button or press **ALT**.

② The most recent items accessed from the Epic menu appear in the Recent section.

③ Click the star next to one of the Recent items to mark it as a favorite.

④ Favorites display at the top of the Epic menu for convenient access.

> **TIP:** To quickly access a specific favorite, press **ALT** to launch the Epic menu, and then press the number that corresponds to your favorite. In the screenshot to the left, pressing **ALT+1** opens the Patient Lookup window to search for a patient's chart to addend.

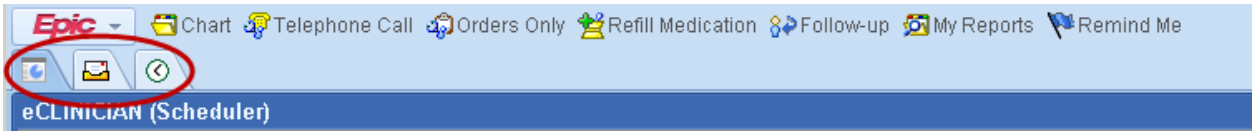
HYPERSPACE TOOLBAR

The Hyperspace or Main toolbar provides you with quick access to commonly used features. With the click of a button you can start a Telephone Call encounter or create an Orders Only encounter. The buttons on your Hyperspace toolbar depend on your security/permissions in ***e*CLINICIAN**.

HOME ACTIVITY MINI-TABS

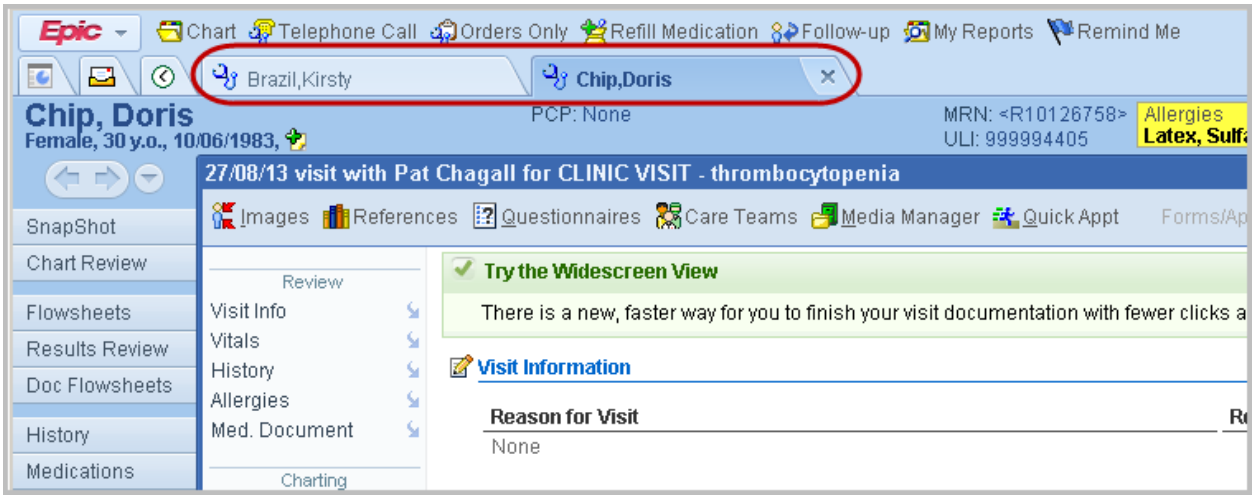
Each Home activity is represented by a mini-tab (and a unique icon) so that you can access it with a single click.

In the screenshot below, mini-tabs are shown for the ***e*CLINICIAN** Dashboard, the In Basket and the Schedule (Multiple Provider Schedule) activities.



Access a Home activity by clicking the respective mini-tab, or use **CTRL**+**ALT**+**1** to access the first mini-tab, **CTRL**+**ALT**+**2** to access the second mini-tab, etc.

WORKSPACES



In addition to the mini-tabs, the workspace tabs area can include patient workspaces or report-based workspaces.

You can have up to four workspaces open at one time.

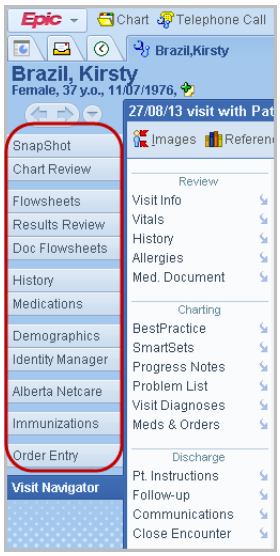
Best Practice - Close Patient Workspaces

Although you can have up to four workspaces open at one time, for patient confidentiality and to prevent charting errors, it is a best practice to exit patient workspaces when you are not actively charting. You can easily return to the patient's workspaces to complete your charting later.

ACTIVITIES

An activity is a window within a workspace, or in the case of a patient workspace, part of the patient's chart.

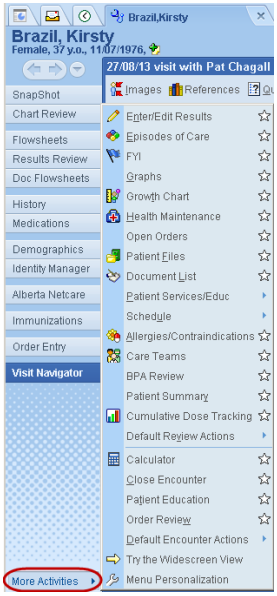
Common activities display on the left-hand side of the patient workspace as tabs. Clicking an activity tab takes you to that activity.



You can work in different activities while in a single workspace.

MORE ACTIVITIES MENU

Activities not found immediately in the patient workspace are accessible from the More Activities menu, located at the bottom of the activity tab list.



The More Activities menu includes workspace-specific activities that a user might not regularly access, such as FYIs, Growth Charts, and Enter/Edit Results. From here you can also add activity tabs to the default view.

> **TIP:** To learn how to customize the list of activity tabs, refer to the **Personalize *e*CLINICIAN** section.

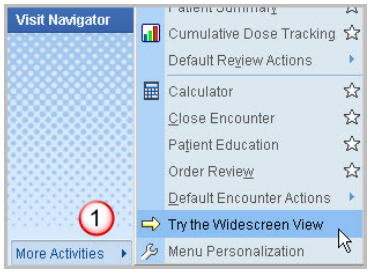
You can also use the **CTRL**+**D** keyboard combination to open the More Activities menu.

WIDESCREEN FEATURE

The Widescreen feature allows physicians to navigate through an office visit with minimal scrolling and clicking, by grouping navigator sections together.

Your screen resolution must be at least 1280 pixels in order to access this feature.

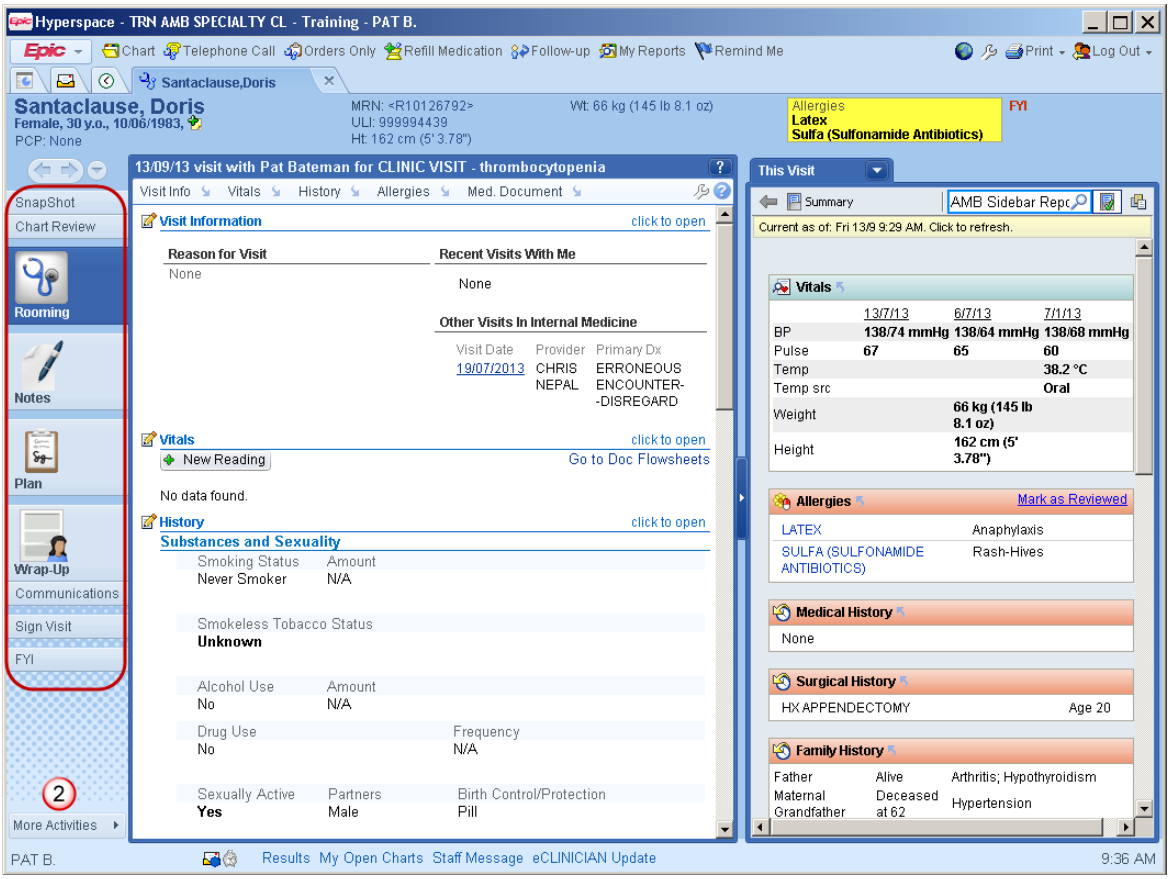
1. To access the Widescreen view, from the bottom of the Activity tab list, select **More Activities > Try Widescreen View**.



In the Widescreen view, navigator sections are grouped into the following activities.

- Rooming contains:
  - Visit Information,
  - Vitals,
  - History,
  - Allergies and
  - Medication Documentation sections.
- Notes contain the Progress Notes section and the various note options.

- Plan contains:
  - Best Practice Advisories
  - the Problem List
  - Visit Diagnoses
  - SmartSets
  - Meds & Orders sections
- Wrap Up contains:
  - Patient Instructions
  - Follow-Up
  - After Visit Summary
- SnapShot, Chart Review, Communications and Sign Visit continue to display as activity tabs.



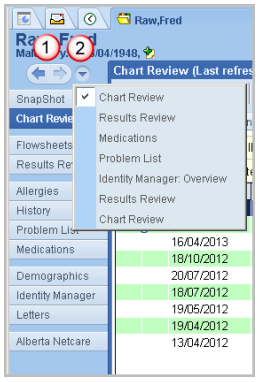
A Sidebar Report is available to enable easy access to other sections of the chart.

2. To return to the standard view, select **More Activities > Turn Off Widescreen View**.

NAVIGATION BUTTONS

① Use the Back and Forward buttons at the top of the activity tab list to move back and forth between activities. These buttons support the shortcuts **ALT**+left arrow and **ALT**+right arrow.

② Use the drop down arrow to the right of the Back and Forward button to display a list of the ten most recently accessed activities visited for the current patient workspace.

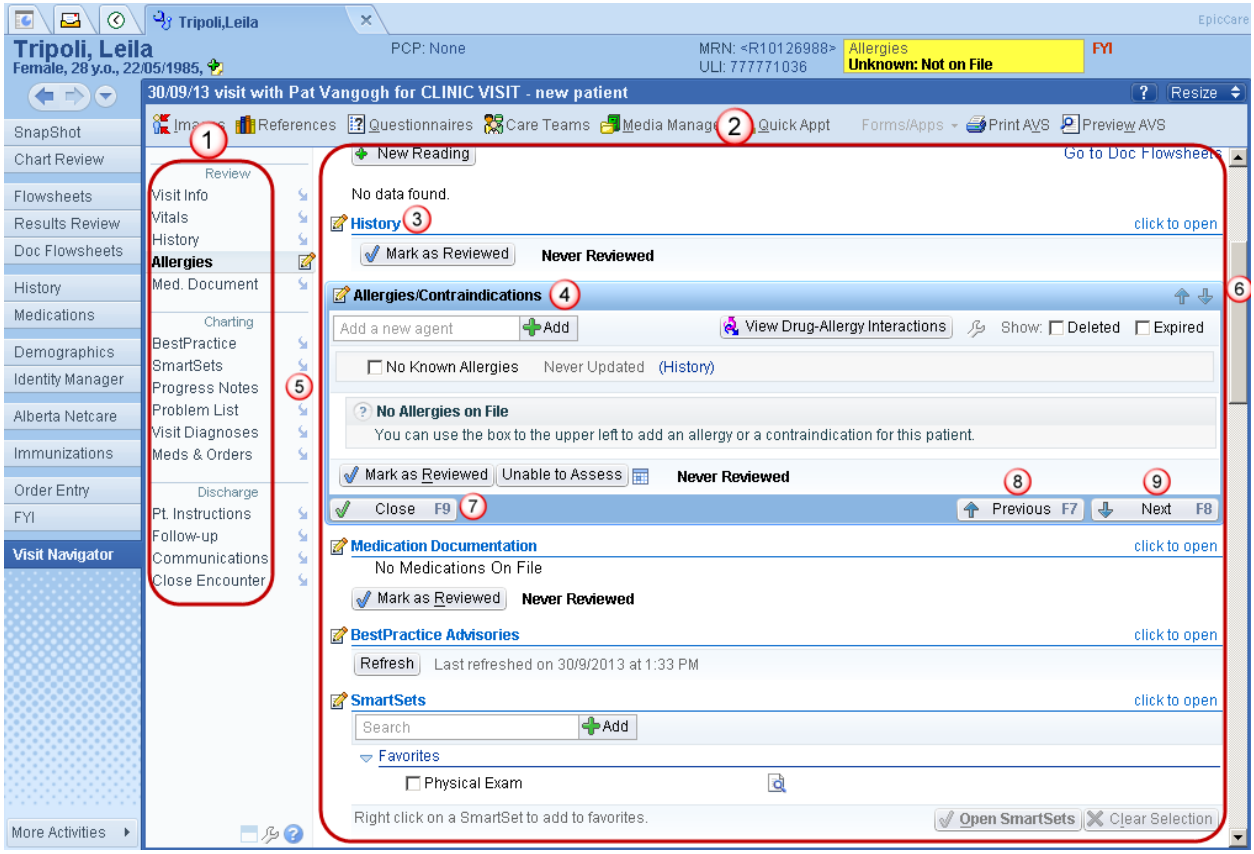


NAVIGATORS

Another example of an activity is the ***Visit Navigator***.

Each workflow can have its own navigator to lay out a path for that workflow, whether it is a telephone encounter, refill encounter or the work that is done by various clinicians during a patient encounter.

There are several features of the navigator with which you should familiarize yourself.



① **TABLE OF CONTENTS (LEFT-HAND PANE)**: The navigator table of contents contains sections (e.g. Visit Info and Vitals) that are grouped into topics (e.g. Review). These sections are where you do your documentation. You can move as needed between appropriate sections. The sections in a navigator can change depending on the user's workflow.

> **TIP:** To learn how to customize the table of contents, refer to the **Personalize *e*CLINICIAN** section.

② **RIGHT-HAND PANE**: displays the information that was previously documented in a section or in a related activity.

③ **REVIEW MODE**: This is default mode for the right-hand pane of the navigator.

④ **EDIT MODE**: This is the mode used for documentation. To open a section in Edit mode:

- From the navigator table of contents, click the corresponding section heading.
- From the right-hand pane, next to corresponding section heading, click the paper and pencil icon.
- From the right-hand pane, to the far right of the corresponding section heading, click **click to open**.

⑤**BLUE ARROW**: Each section in the table of contents has a downward-pointing blue arrow which takes you to the corresponding section in the right-hand pane, in review mode.

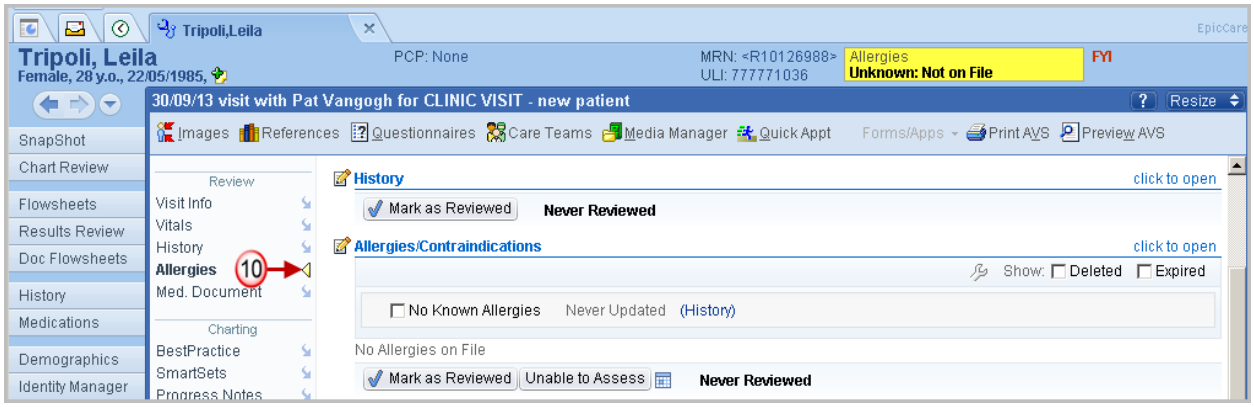
⑥ **SCROLL BAR**: You can also use the scroll bar to navigate through the right-hand pane of the navigator.

⑦ **CLOSE BUTTON:** Closes an open section and reverts the navigator back to review mode.

⑧ **PREVIOUS BUTTON:** Closes the current section and automatically opens the previous section in edit mode.

⑨ **NEXT BUTTON:** Closes the current section and automatically opens the next section it in edit mode.

⑩ **YELLOW TRIANGLE:** When all navigator sections are closed, in the navigator table of contents, a yellow triangle displays. This symbol indicates the most recently opened section.



KEYBOARD NAVIGATION REFERENCE

Instead of using the mouse, you might prefer to navigate the system using keyboard shortcuts. Learning shortcuts can save you time because you can keep your hands on the keyboard instead of switching between the keyboard and the mouse.

> **TIP**: For a complete list of Keyboard and Date shortcuts, refer to **Appendix E: Keyboard Shortcuts for Windows Users & Appendix F: Keyboard Shortcuts for Mac Users**.

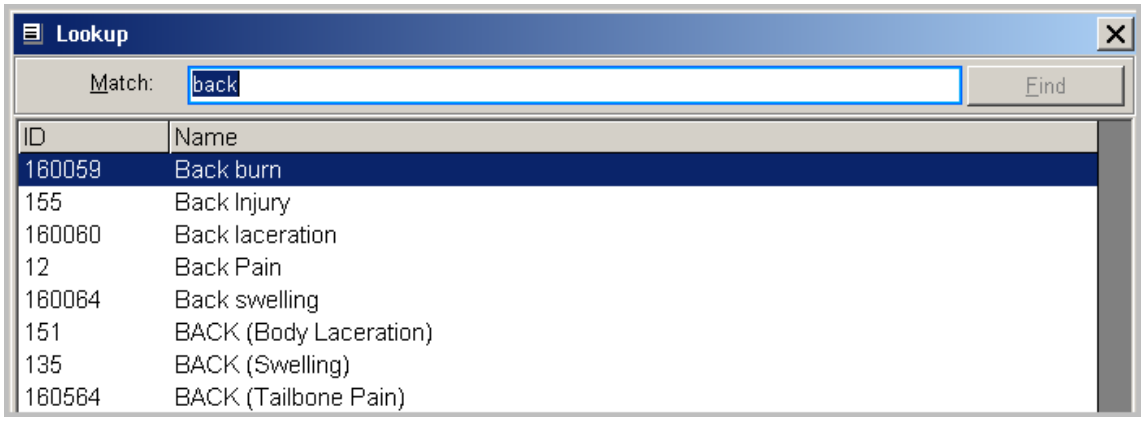
CHOOSE VALUES FROM LISTS

Throughout this guide you will see the term ***completion matching***.

Completion matching is a term we use to describe a quick way to search for information in a list of values or pick lists.

Any time you see a field with a magnifying glass, which we call the **Selection** Tool, you can use completion matching. Note that you can also type the full word but completion matching is faster and can eliminate errors due to misspelling.

1. Start by typing the first few letters of a word and press **ENTER**. The system displays a list of all the choices starting with the letters you typed.



2. Make your selection from this filtered list and press **ENTER** or click **Accept**.

USE SMARTTOOLS

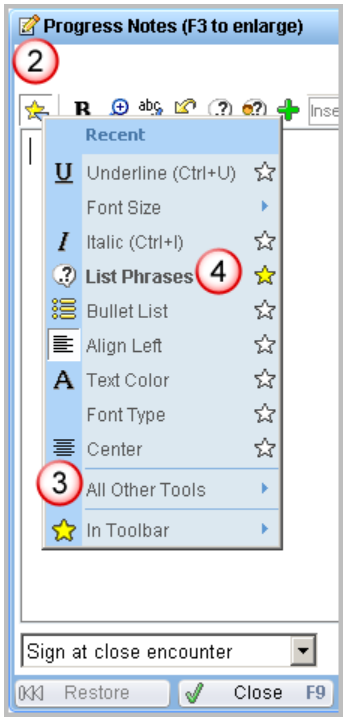
As you write notes and letters and enter other text in ***e*CLINICIAN**, you'll notice that many text fields are configured for the use of SmartTools. Using SmartTools, you can pull in entire blocks of text or information with minimal typing. This information can even be specific to the patient and pulled in from elsewhere in the chart or visit. You can tell that a text field allows the use of SmartTools when you see the SmartTool-enabled toolbar, shown below.

THE SMARTTOOL TOOLBAR

The SmartTool toolbar comes with a set of default tools. You can customize the toolbar by adding additional tools and removing ones you do not regularly use.

To add or remove additional tools from your toolbar:

1. Access any SmartTool-enabled section.
2. From the top left of the SmartTool toolbar, click on the yellow star with the downward pointing arrow. A menu of additional buttons displays.
3. To see more options, click All Other Tools.
4. To add a tool to your toolbar, click the white star. The star turns yellow and the tool appears on your toolbar.



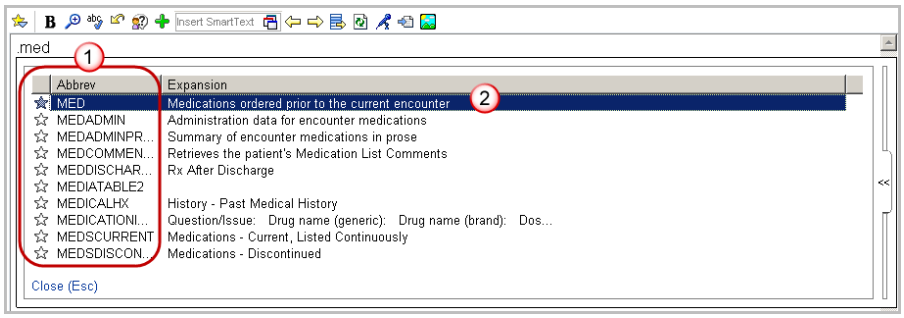
5. To remove a tool, click the yellow star. The star turns white.

There are four types of SmartTools:

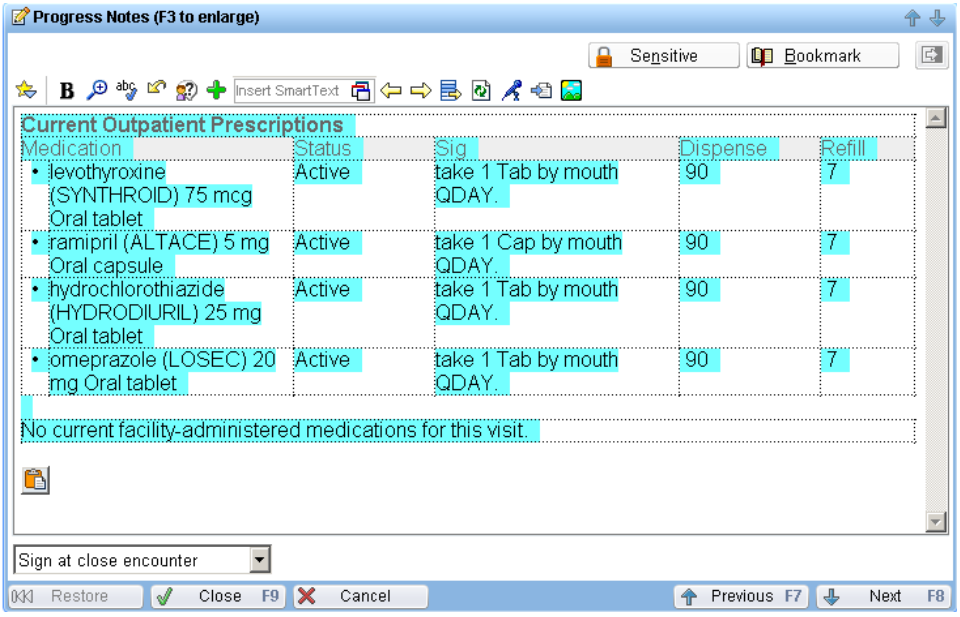
SmartTool Name	Description
Smart*Links*	Pulls in information that has been charted elsewhere in the chart. For example current medical problems, allergies, and lab data.
Smart*Phrases*	Expands into a word, phrase, or paragraph of text. Often called "dot phrases" because they are invoked by typing a period (dot) followed by the SmartPhrase name. SmartPhrases are often used to pull in a portion of a progress note.
Smart*Lists*	Provides a set of pre-configured values from which you select. For example, you might have access to a SmartList with symptom onset values such as acute, chronic, gradual, and sudden.
Smart*Texts*	Provides templates or blocks of text used to reduce documentation time. A SmartText often includes embedded SmartLinks and SmartLists. For example, you might use a SmartText to pull an assessment template into your progress note.

WORK WITH SMARTLINKS

1. From a SmartTool-enabled text box, type a period (.) followed by the SmartLink name. For example, type ***.med***. A pop-up box displays a list of SmartLinks that match what you typed.
2. From the List, click the desired SmartLink and then to accept it, press either:
   - the **SPACEBAR** to continue typing on the same line, or
   - **ENTER** to jump to a new line.



The linked information is added to your note.



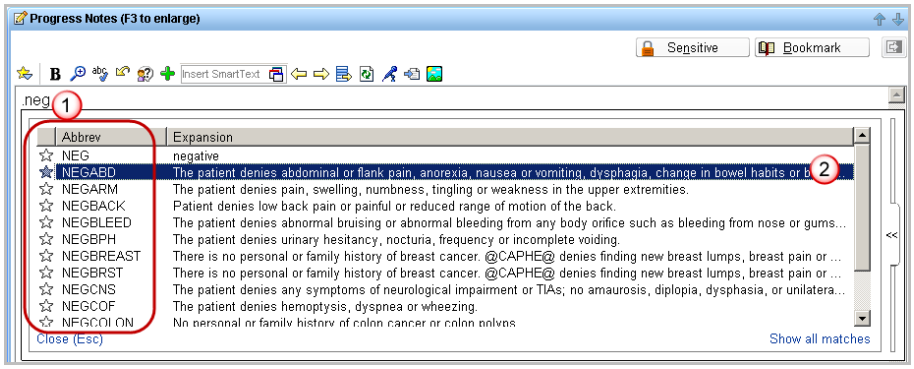
TIP 1: The blue background indicates that the information was added via a **SmartLink**.

TIP 2: Some SmartLinks are refreshable. This means that if you add new information to the source information, you can return to the area where you used the SmartLink and click **Refresh** to pull in the updated information.

TIP 3: To see a listing of some of the SmartLinks available, refer to **Appendix C: Useful SmartLinks**.

WORK WITH SMARTPHRASES

1. From a SmartTool-enabled text box, type a period (.) followed by the SmartPhrase name. For example, type ***.neg***. A pop-up box displays a list of SmartPhrases that match what you typed.
2. From the List, click the desired SmartPhrase and then to accept it, press either:
   - the **SPACEBAR** to continue typing on the same line, or
   - **ENTER** to jump to a new line.


Progress Notes (F3 to enlarge)
Sensitive
Bookmark
Insert SmartText
.neg
1
Abbrev
Expansion
NEG
negative
NEGABD
The patient denies abdominal or flank pain, anorexia, nausea or vomiting, dysphagia, change in bowel habits or b
2
NEGARM
The patient denies pain, swelling, numbness, tingling or weakness in the upper extremities.
NEGBACK
Patient denies low back pain or painful or reduced range of motion of the back.
NEGBLEED
The patient denies abnormal bruising or abnormal bleeding from any body orifice such as bleeding from nose or gums...
NEGBPH
The patient denies urinary hesitancy, nocturia, frequency or incomplete voiding.
NEGBREAST
There is no personal or family history of breast cancer. @CAPHE@ denies finding new breast lumps, breast pain or ...
NEGBRST
There is no personal or family history of breast cancer. @CAPHE@ denies finding new breast lumps, breast pain or ...
NEGCNS
The patient denies any symptoms of neurological impairment or TIAs; no amaurosis, diplopia, dysphasia, or unilatera...
NEGCOF
The patient denies hemoptysis, dyspnea or wheezing.
Close (Esc)
Show all matches

The phrase appears in your note.

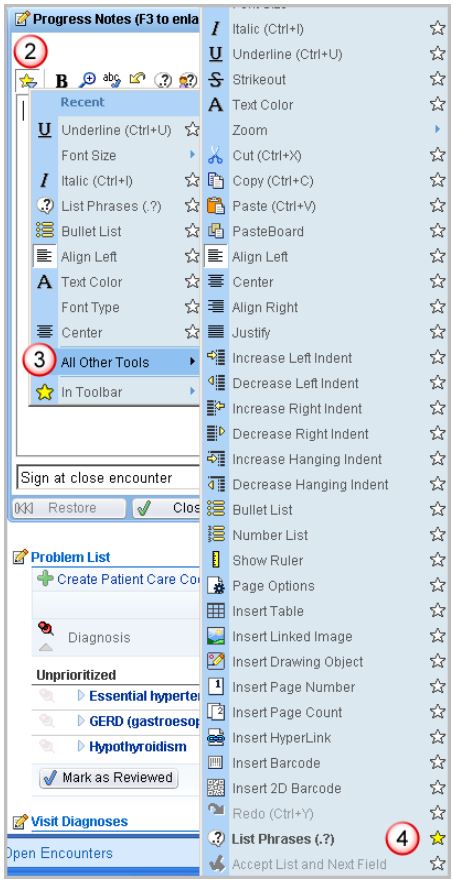
TIP 3: To see a listing of some of the System SmartPhrases available, refer to **Appendix B: System SmartPhrase Examples & Naming Conventions**.

VIEW A LIST OF AVAILABLE SMARTLINKS AND SMARTPHRASES

You can use the SmartLink/Phrase Butler to search for available SmartLinks and SmartPhrases. The SmartLink/Phrase Butler may need to be added to your toolbar.

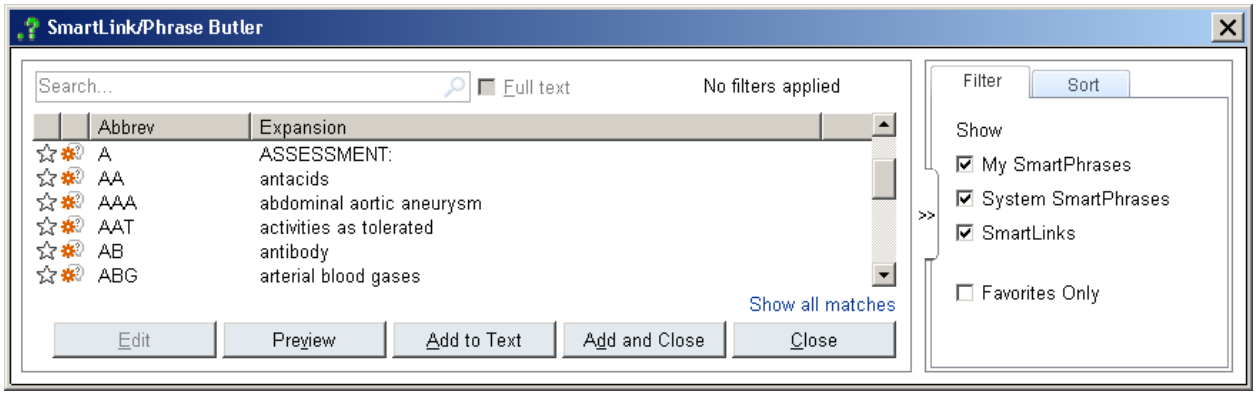
To add the SmartLink/Phrase Butler:

1. Access any SmartTool-enabled section.
2. From the top left of the SmartTool toolbar, click on the yellow star with the downward pointing arrow.
3. To access the SmartLink/Phrase Butler, click on All Other Tools.
4. To the right of the SmartLink/Phrase Butler ( ) click on the white star to the right. The star turns yellow and the SmartLink/Phrase Butler tool appears on your toolbar.



Launch the Butler from any SmartTool-enabled text box by clicking the (**List Phrases**) button.

TIP 1: You can also type **.?** in any SmartTool-enabled text box.



Within the SmartLink/Phrase Butler, you can:

- Insert SmartLinks and SmartPhrases into SmartTool-enabled fields,
- Search for specific SmartLinks and SmartPhrases using the **Search** field,
- Mark SmartLinks and SmartPhrases as favorites,
- Edit your personal SmartPhrases,
- Filter by favorites and type of SmartTool. For example, a user can choose to filter out SmartLinks but not SmartPhrases, and
- Sort the list of SmartLinks and SmartPhrases alphabetically, by favorite or by usage. When sorted, the SmartTools used most frequently appear at the top of the list.

> **TIP 2**: To quickly identify the most useful SmartLinks or SmartPhrases, click the star to the left of the SmartLink to mark it as a favorite.

The following table describes how to use some of the features of the SmartLink/Phrase Butler.

Feature	Description
Abbrev column	Shows the text to enter after a period to summon the SmartPhrase or SmartLink.
Expansion column	Shows the text each SmartPhrase or SmartLink pulls in.
Search Field	Type a SmartLink or SmartPhrase name in the Search field and press ENTER to begin the search. The search returns matching text found in the Abbrev and Expansion columns.
Full text checkbox	Select the Full text checkbox to perform a full text search. A full text search not only returns matching text found in the Abbrev and Expansion columns, but also text from the description of the SmartPhrase or SmartLink.
Clear filters button	Click Clear filters to remove any filters selected on the Filter tab and to remove any text entered in the Search field.
Edit button	Click Edit to open the currently highlighted SmartPhrase. This button is enabled only for SmartPhrases that you have security to edit.
Preview button	**Not recommended** - Due to potential formatting issues, the most reliable way to preview a SmartPhrase or SmartLink is usually to insert it in the SmartTool-enabled field, then remove it if the results are not as desired.
Add to Text button	Click Add to Text to add the selected SmartLink or SmartPhrase to the text of the SmartTool-enabled field at the current cursor position. Note that a faster alternative to clicking Add to Text is double-clicking the SmartLink or SmartPhrase.
Add and Close button	Use to add the selected SmartLink or SmartPhrase to the text of the SmartTool-enabled field and close the SmartLinks and SmartPhrases window.
Favorites Column in the SmartLink/Phrase Table	Click the star symbol to add the SmartLink or SmartPhrase to your favorites, and click it again to remove it from your favorites.
SmartTool Type	= SmartLink

Feature	Description
column in the SmartLink/Phrase Table	= User SmartPhrases = System SmartPhrases Note that when you hover over the symbol with your cursor, a ToolTip identifies the type of SmartTool.
SmartLink/Phrase Option Drawer	Click the opening (<<) or closing (>>) chevrons to open or close the SmartLink/Phrase Option Drawer. The Option Drawer contains the Filter tab options and the Sort tab options. Note that the Option Drawer opens automatically when you first open the SmartLink/Phrase Butler. Whether it is closed or opened upon subsequent uses depends on how you last left it.
Filter Tab Options	• Select **My SmartPhrases** to include user-created SmartPhrases in the SmartLinks and SmartPhrases table. • Select **System SmartPhrases** to include system SmartPhrases in the SmartLinks and SmartPhrases • Select **SmartLinks** to include SmartLinks in the SmartLinks and SmartPhrases table. • Select **Favorites Only** to include only your favorite SmartPhrases or SmartLinks, based on which other checkboxes are selected, in the SmartLinks and SmartPhrases table.

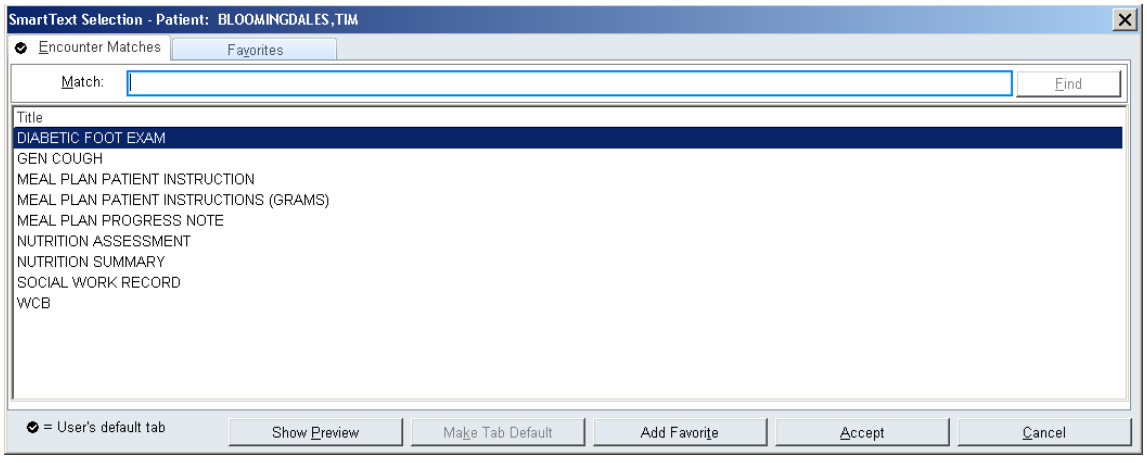
WORK WITH SMARTTEXT

1. From a SmartTool-enabled text box, click (Open Selection Entry). The SmartText Selection window displays.

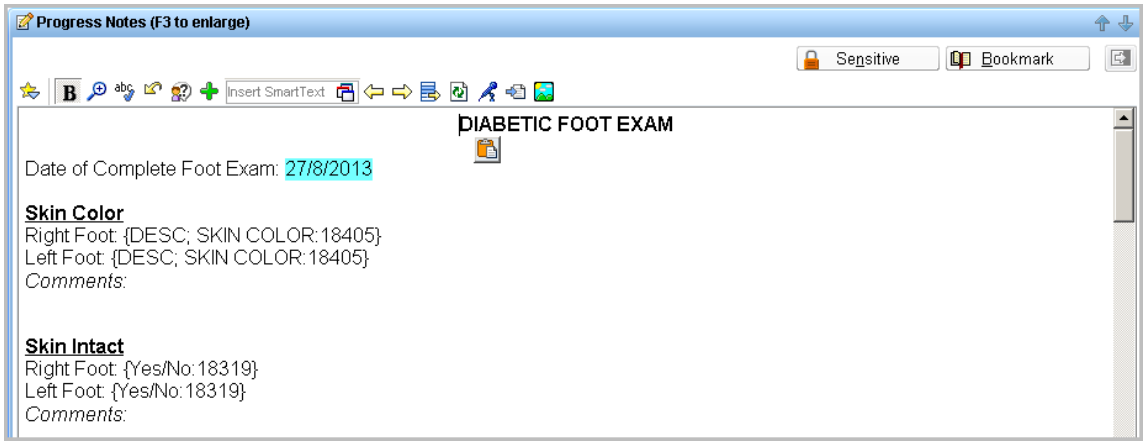
   TIP: You can also type the name of the SmartText directly in the **Insert Smart Text** field.

   Note that the SmartText available to you varies depending on the area of the chart you are using.

2. Select the appropriate SmartText and click **Accept**.



The SmartText displays in the SmartTool-enabled text box.



The SmartText may contain SmartLists that you have to manage. The next topic describes how to work with SmartLists.

WORK WITH SMARTLISTS

SmartLists are found within SmartPhrases and SmartText. They cannot be summoned on their own and users cannot create them.

The following table describes how to work with SmartLists using the keyboard, mouse or both.

Keyboard	
To open list	Press F2.
To make a selection: Single Response (yellow background)	Navigate through list using: • Press the UP or Down arrows, or • Type the first letter of the item in the list, and then • Press ENTER to accept the selection and to move to the next SmartList.
To make a selection: Multiple Response (blue background)	Navigate through list using: • Press the UP or Down arrows, or • Type the first letter of the item in the list, • To select the item and move to next selection, press the SPACEBAR. • When all selections are complete, press ENTER to accept the selection and to move to the next SmartList.
To accept the default selections	Press ENTER to accept the defaults and move to the next SmartList.

Mouse	
To open list	• Click in the note anywhere before the first list and then click Next Field (right pointing yellow arrow button), or • Right-click and select Next Field.
To make selections: Single- and Multiple-Response	"Left-click to pick, right-click to stick": • Left-click the item(s) to select, then • Right-click to accept and continue.
Accept default selections	Right-click to accept default selections.
Combination: Keyboard and Mouse	
Press F2 to open the list	"Left-click to pick, right-click to stick" and move on.

TIP: To ensure that you have completed all of the SmartLists in your note, press **F2** one more time to locate any **missing lists**.

Incomplete SmartLists

The system cannot close encounters if SmartLists are left unfinished. You must make a selection for each SmartList within SmartText.

CREATE PERSONAL SMARTPHRASES

There are two types of SmartPhrases:

- System SmartPhrases are created by Epic or the ***e*CLINICIAN - EMR** project team to serve the needs of all users.
- User or personal SmartPhrases are created by end-users.

Building your own personal SmartPhrases takes very little time and can drastically speed up your workflow. Refer to the ***Manage Personal SmartPhrases*** section.

REVIEW THE PATIENT'S CHART

It might be your practice to review patient information shortly before seeing the patient in your office or at your clinic. This review of patient information might happen a day or two before you see the patient or even immediately before you see the patient in the exam room. Receiving new information about the patient may also require you to lookup patient information long after the patient's appointment.

This chapter details the various ***e*CLINICIAN** features that assist you with locating the patient's chart and reviewing the pertinent information.

The following main topics are covered in this chapter:

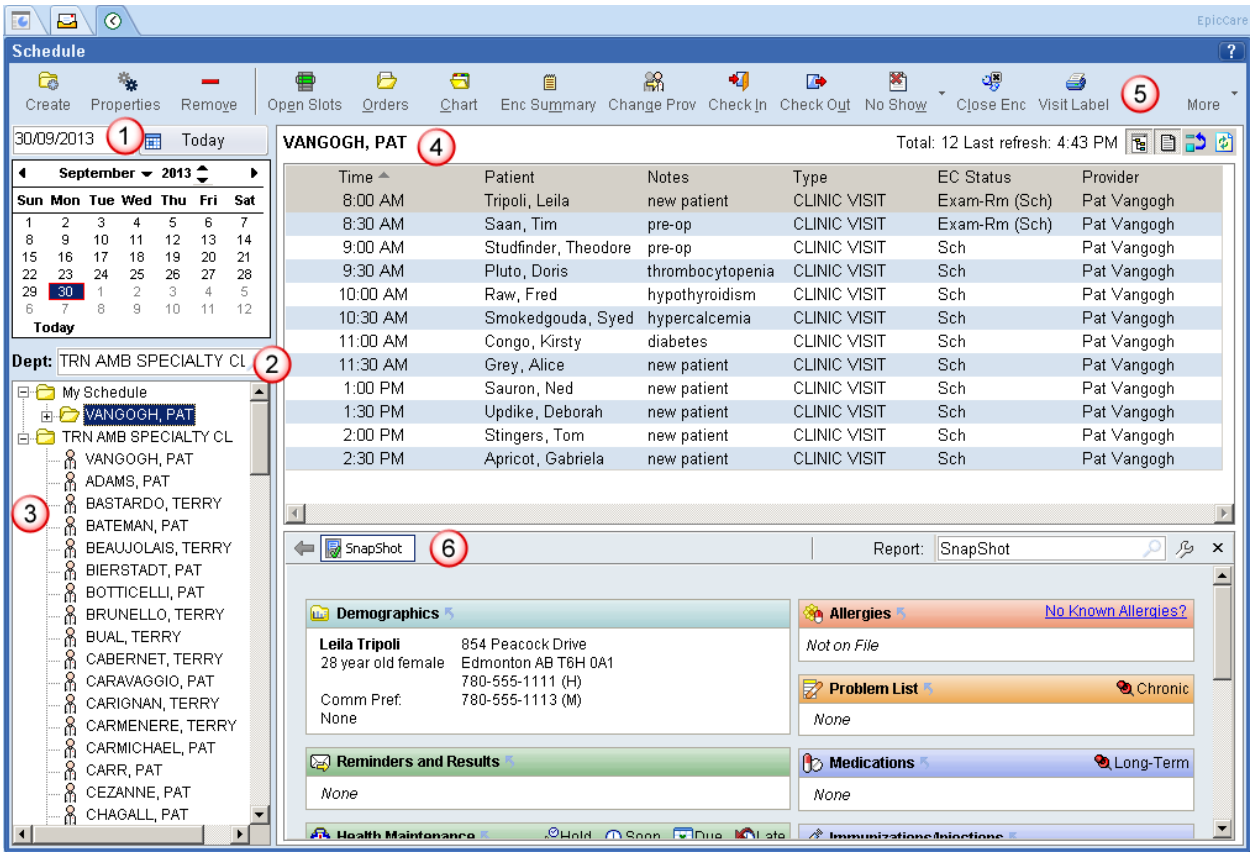
- View your Daily Schedule
- Review Chart Modes
- Find a Patient's Chart when the Patient is not Scheduled
- Break the Glass for Masked Patients
- Review Basic Patient Information

VIEW YOUR DAILY SCHEDULE

The Schedule activity is also known as the ***Multi Provider Schedule*** (MPS). From the Schedule activity, you can view daily appointment schedules for yourself and for any combination of providers and resources within your department.

It is the hub that helps you manage both the patients and the health care providers that patients are scheduled to see during the course of a day. It also gives you quick access to a patient's workspace where you can review the chart, document findings, place orders, and much more.

Features of the Schedule activity include the following:



① **CALENDAR**: View appointments scheduled for past and future dates using the calendar.

> **TIP 1:** Use date shortcuts in the date field to navigate through the calendar, where t=today, w=week, m=month and y=year. E.g. an end date of 6 weeks from now can be entered as w+6.

② **DEPT. FIELD**: Select the department (clinic/specialty) you want to view. The first time you open the schedule, your login department displays automatically.

③ **PROVIDER SCHEDULES**: With appropriate security access, you can choose to display the schedules of other providers within a particular department.

④ **DAILY SCHEDULE**: Shows the appointments for a particular provider with various columns. Appointments may be sorted by time, patient name, visit type, etc. You can change the display of your schedule, create new views of your schedule and add additional reports to the Schedule activity. You can also create combined schedules, across multiple departments or providers

> **TIP 2**: For details on how to customize the Schedule activity, refer to the **Personalize *e*CLINICIAN** section.

⑤ **ACTIVITY TOOLBAR**: Contains buttons that allow you to perform actions specific to the Schedule activity, and for whichever patient is selected in the schedule.

⑥ **REPORT TOOLBAR**: You can view various reports from this toolbar, using the **Report** field, or available buttons. These reports display below the toolbar. The default report is the Snapshot.

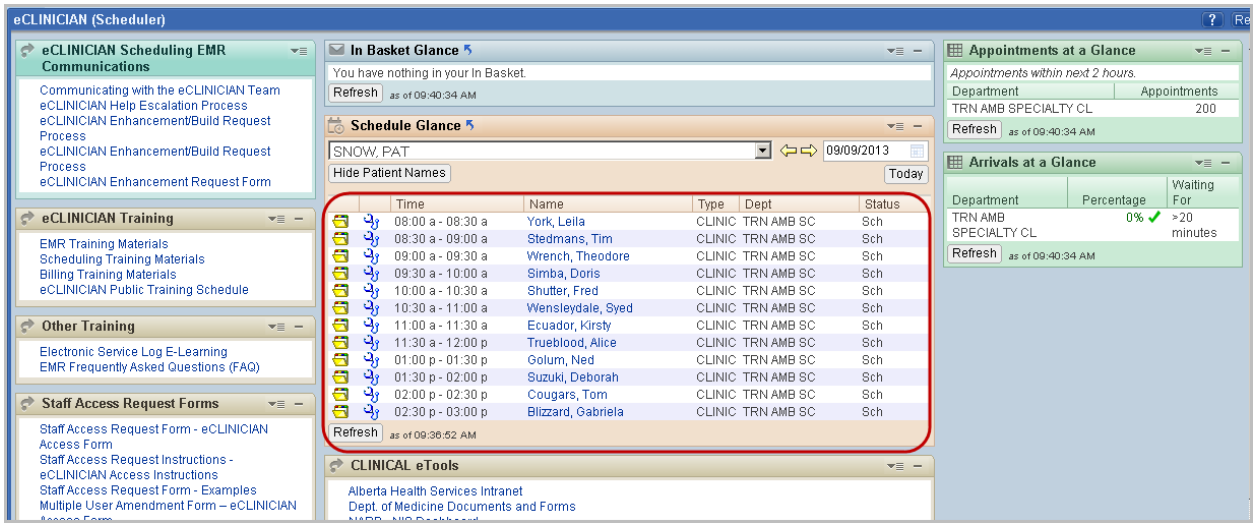
> **TIP 3**: For details on how to add reports to the Report toolbar, refer to the **Personalize *e*CLINICIAN** section.

ACCESS YOUR SCHEDULE

If patients are scheduled to see you today, there are several methods you can use to view your schedule.

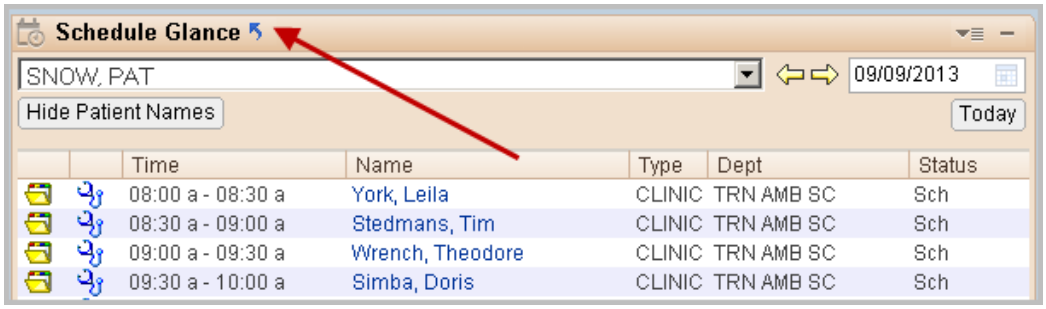
METHOD 1: USE THE SCHEDULE GLANCE SECTION

If you are the provider that patients have been scheduled to see, you can use the Schedule Glance section on the ***e*CLINICIAN** Dashboard to view your schedule.


eCLINICIAN (Scheduler)
eCLINICIAN Scheduling EMR Communications
Communicating with the eCLINICIAN Team
eCLINICIAN Help Escalation Process
eCLINICIAN Enhancement/Build Request Process
eCLINICIAN Enhancement/Build Request Process
eCLINICIAN Enhancement Request Form
eCLINICIAN Training
EMR Training Materials
Scheduling Training Materials
Billing Training Materials
eCLINICIAN Public Training Schedule
Other Training
Electronic Service Log E-Learning
EMR Frequently Asked Questions (FAQ)
Staff Access Request Forms
Staff Access Request Form - eCLINICIAN Access Form
Staff Access Request Instructions - eCLINICIAN Access Instructions
Staff Access Request Form - Examples
Multiple User Amendment Form – eCLINICIAN
In Basket Glance
You have nothing in your In Basket.
Refresh
Schedule Glance
SNOW, PAT
09/09/2013
Hide Patient Names
Today
Time
Name
Type
Dept
Status
08:00 a - 08:30 a York, Leila CLINIC TRN AMB SC Sch
08:30 a - 09:00 a Stedmans, Tim CLINIC TRN AMB SC Sch
09:00 a - 09:30 a Wrench, Theodore CLINIC TRN AMB SC Sch
09:30 a - 10:00 a Simba, Doris CLINIC TRN AMB SC Sch
10:00 a - 10:30 a Shutter, Fred CLINIC TRN AMB SC Sch
10:30 a - 11:00 a Wensleydale, Syed CLINIC TRN AMB SC Sch
11:00 a - 11:30 a Ecuador, Kirsty CLINIC TRN AMB SC Sch
11:30 a - 12:00 p Trueblood, Alice CLINIC TRN AMB SC Sch
01:00 p - 01:30 p Golum, Ned CLINIC TRN AMB SC Sch
01:30 p - 02:00 p Suzuki, Deborah CLINIC TRN AMB SC Sch
02:00 p - 02:30 p Cougars, Tom CLINIC TRN AMB SC Sch
02:30 p - 03:00 p Blizzard, Gabriela CLINIC TRN AMB SC Sch
Refresh
CLINICAL eTools
Alberta Health Services Intranet
Dept. of Medicine Documents and Forms
Appointments at a Glance
Appointments within next 2 hours.
Department
Appointments
TRN AMB SPECIALTY CL
200
Refresh
Arrivals at a Glance
Department
Percentage
Waiting For
TRN AMB SPECIALTY CL
0%
>20 minutes
Refresh

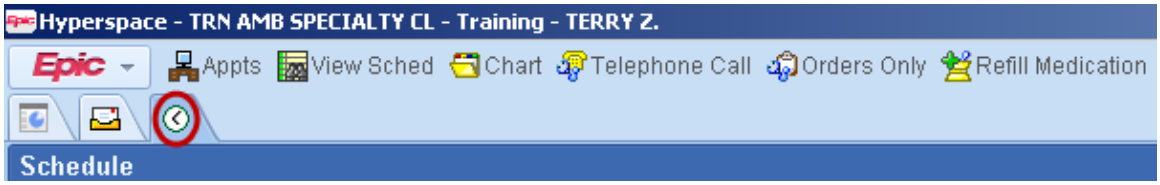
METHOD 2: USE THE SCHEDULE GLANCE TITLE BAR

Click the Schedule Glance title bar on the ***e*CLINICIAN** Dashboard to view your schedule.



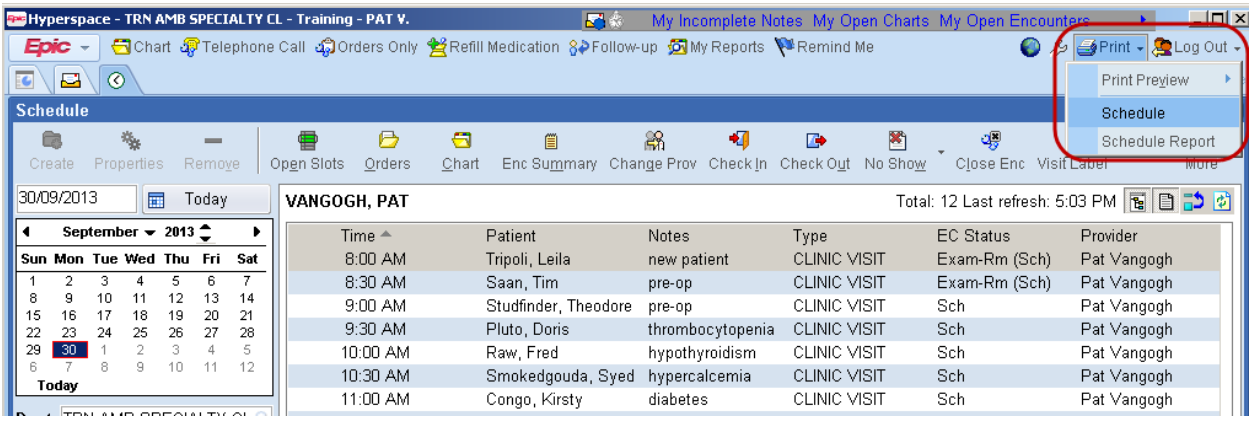
METHOD 3: USE THE SCHEDULE MINI-TAB

Select the Schedule mini-tab to view your schedule.



PRINT A COPY OF YOUR SCHEDULE

From the Schedule activity, on the right-hand side of the Hyperspace toolbar, click **Print**>**Schedule**. The report (day sheet) is sent to the appropriate printer.

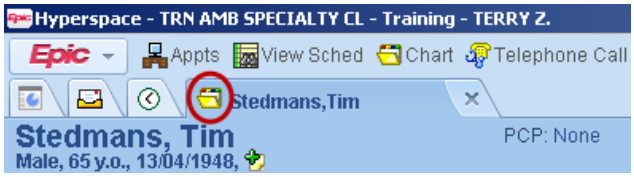


TIP: If you select **Schedule Report**, whichever report displays in the lower right-hand section of the Schedule activity prints.

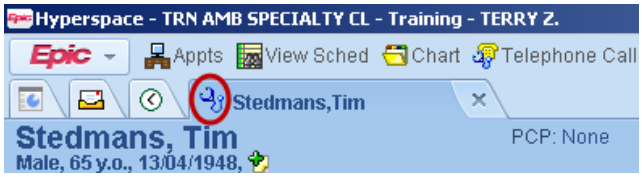
REVIEW CHART MODES

You can open a patient's record in ***e*CLINICIAN** in one of two ways:

- ***Review*** mode (chart) mode – used to review information about the patient when the patient is not scheduled or prior to a scheduled appointment when the patient has not yet checked in. This mode is indicated by a chart icon.



- ***Documentation*** (encounter) mode – used to document information about the patient. This mode is indicated by a stethoscope icon.



Importance of Opening the Chart in the Correct Mode

It is very important that you do not open a patient's record in documentation mode until they have checked in for their appointment.

Each time you open a patient's record in documentation mode, ***e*CLINICIAN - EMR** creates an encounter report which can be seen on the **Encounter tab** in the Chart Review activity.

If a patient does not show for their appointment and you opened their chart in documentation mode in advance of their appointment, a **blank** Encounter report is filed to the Chart Review activity. These blank Encounter reports take up system resources and can be confusing to other users.

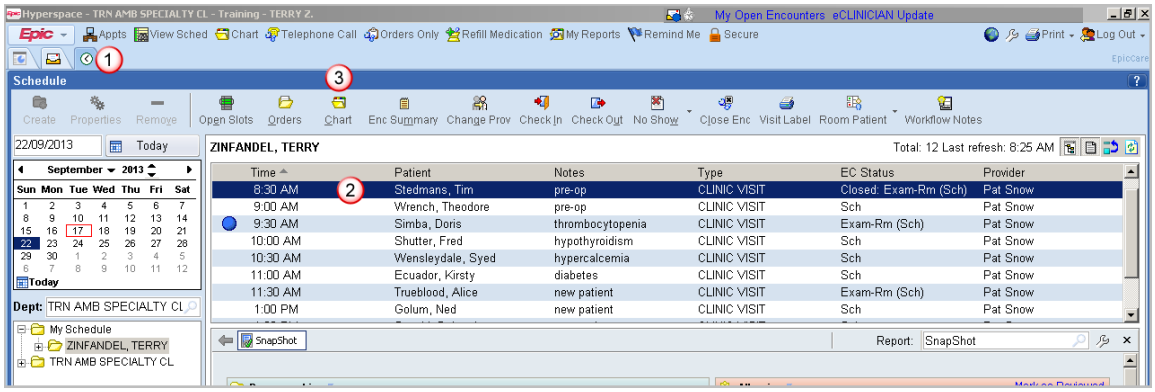
OPEN A SCHEDULED PATIENT'S CHART IN REVIEW MODE

A patient's chart can be opened in ***Review*** mode either from the Schedule activity or from the Schedule Glance section of the ***e*CLINICIAN** Dashboard. The latter method can be used only if the patient has been scheduled to see you.

METHOD 1: FROM THE SCHEDULE ACTIVITY

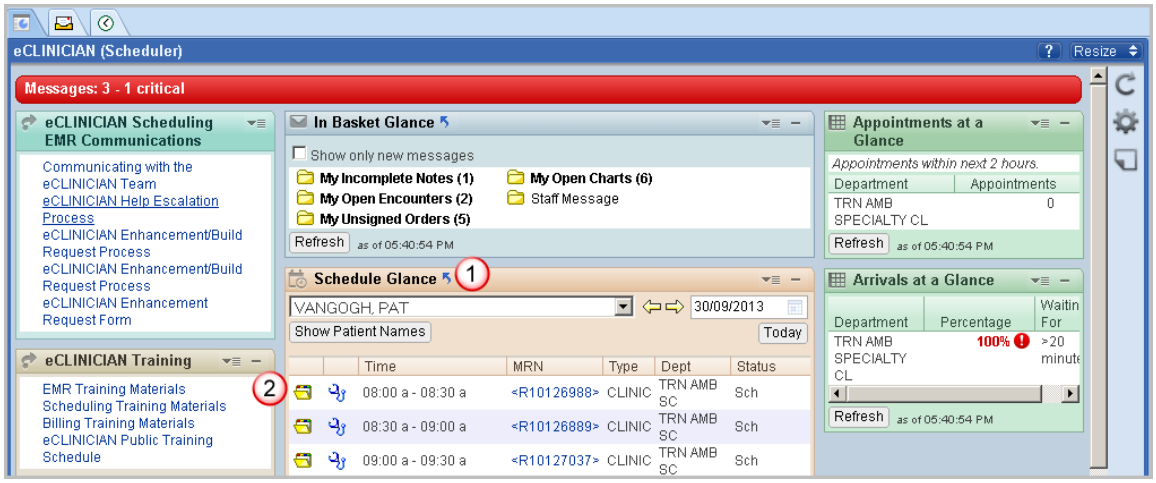
1. Access the Schedule activity.
2. From the schedule (upper right-hand pane), select the patient whose history you want to review.

   From the Schedule activity toolbar, click **Chart**. The patient's workspace displays.



METHOD 2: FROM THE DASHBOARD SCHEDULE GLANCE

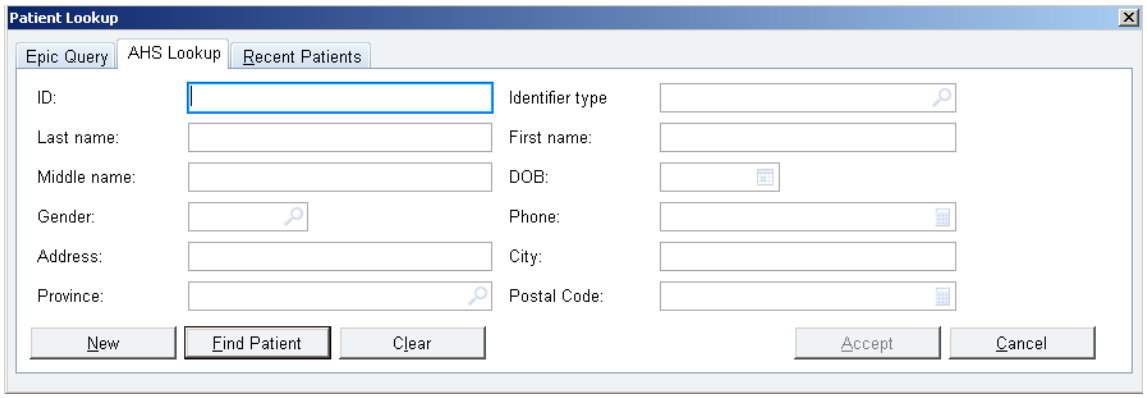
1. From the ***e*CLINICIAN** Dashboard, locate the Schedule Glance section.
2. Locate the appropriate appointment and click . The patient's workspace (chart) displays.



OPEN A PATIENT'S CHART WHEN THE PATIENT IS NOT SCHEDULED

1. From the Hyperspace (main) toolbar, click **Chart**.

The Patient Lookup window opens displaying the AHS Lookup Tab.



Search criteria entered on the AHS Lookup tab make it possible to search a database of all patients who have received medical treatment in Alberta and/or have Alberta Health Care. This database, the AHS Client Registry, has over sixteen million names and is used by other applications including Netcare, VAX and Tandem.

2. From the Patient Lookup window, search for the patient using one of following two methods:

METHOD 1: RECOMMENDED PATIENT LOOKUP

It is important to follow the recommended patient lookup in order to select the correct patient when reviewing or documenting in the chart. From the AHS Lookup Tab, enter the patient's full last name, full first name and the date of birth to ensure the correct patient is being selected.

a) Enter the patient's full Last Name and full First Name in to the appropriate fields.

b) In the **DOB** field, type the patient's date of birth.

c) Click **Find Patient**. The Patient Select window displays.

e) Select your patient and click **Accept**. The patient's workspace displays.

Importance of Selecting the Correct Patient Record

For Non-Hospital Clinics:

Your search may return multiple records that all belong to the same patient. Select the correct record based on the ULI.

For Hospital Clinics:

Your search may return multiple records that all belong to the same patient.

Select the correct record based on the MRN, if it exists. Failure to do this results in an additional MRN being created in your ADT system (VAX or Tandem) when an MRN for your facility may already be assigned to the patient, if you subsequently schedule an appointment.

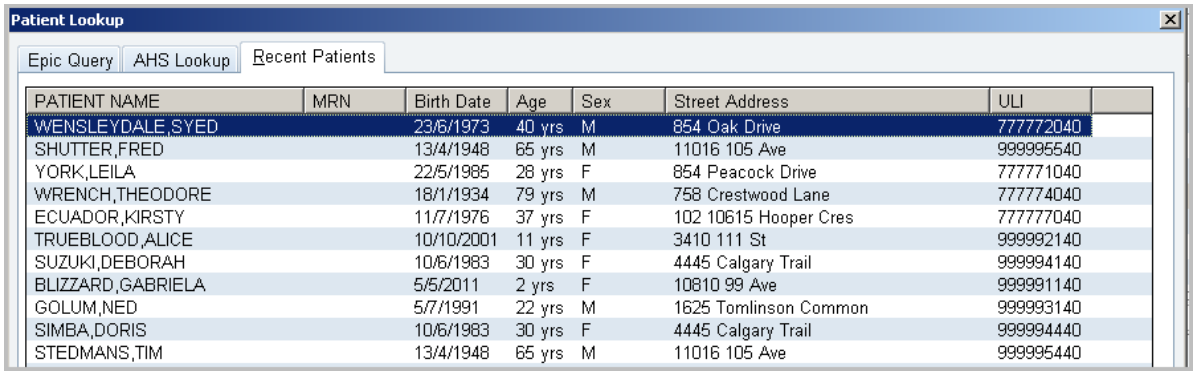
Note: When multiple records for the same patient exist, a **Patient Data Inquiry In Basket message** should be created. A **Patient Data Inquiry** message is sent to the appropriate team and partial or duplicate records are reconciled.

METHOD 2: USE THE RECENT PATIENTS TAB.

The Recent Patients tab displays the last 25 patients that you looked up. The patients display in order of selection, with the most recently selected patient first.

a) Select the Recent Patients tab and locate your patient's record.

b) Click on the selected patient's name. The patient's workspace opens.



PATIENT NAME	MRN	Birth Date	Age	Sex	Street Address	ULI
WENSLEYDALE,SYED		23/6/1973	40 yrs	M	854 Oak Drive	777772040
SHUTTER,FRED		13/4/1948	65 yrs	M	11016 105 Ave	999995540
YORK,LEILA		22/5/1985	28 yrs	F	854 Peacock Drive	777771040
WRENCH,THEODORE		18/1/1934	79 yrs	M	758 Crestwood Lane	777774040
ECUADOR,KIRSTY		11/7/1976	37 yrs	F	102 10615 Hooper Cres	777777040
TRUEBLOOD,ALICE		10/10/2001	11 yrs	F	3410 111 St	999992140
SUZUKI,DEBORAH		10/6/1983	30 yrs	F	4445 Calgary Trail	999994140
BLIZZARD,GABRIELA		5/5/2011	2 yrs	F	10810 99 Ave	999991140
GOLUM,NED		5/7/1991	22 yrs	M	1625 Tomlinson Common	999993140
SIMBA,DORIS		10/6/1983	30 yrs	F	4445 Calgary Trail	999994440
STEDMANS,TIM		13/4/1948	65 yrs	M	11016 105 Ave	999995440

BREAK THE GLASS FOR MASKED PATIENTS

Masking is the process by which a cover or ***mask*** can be applied to the record of a patient who expresses significant concern about his or her data being in an electronic file.

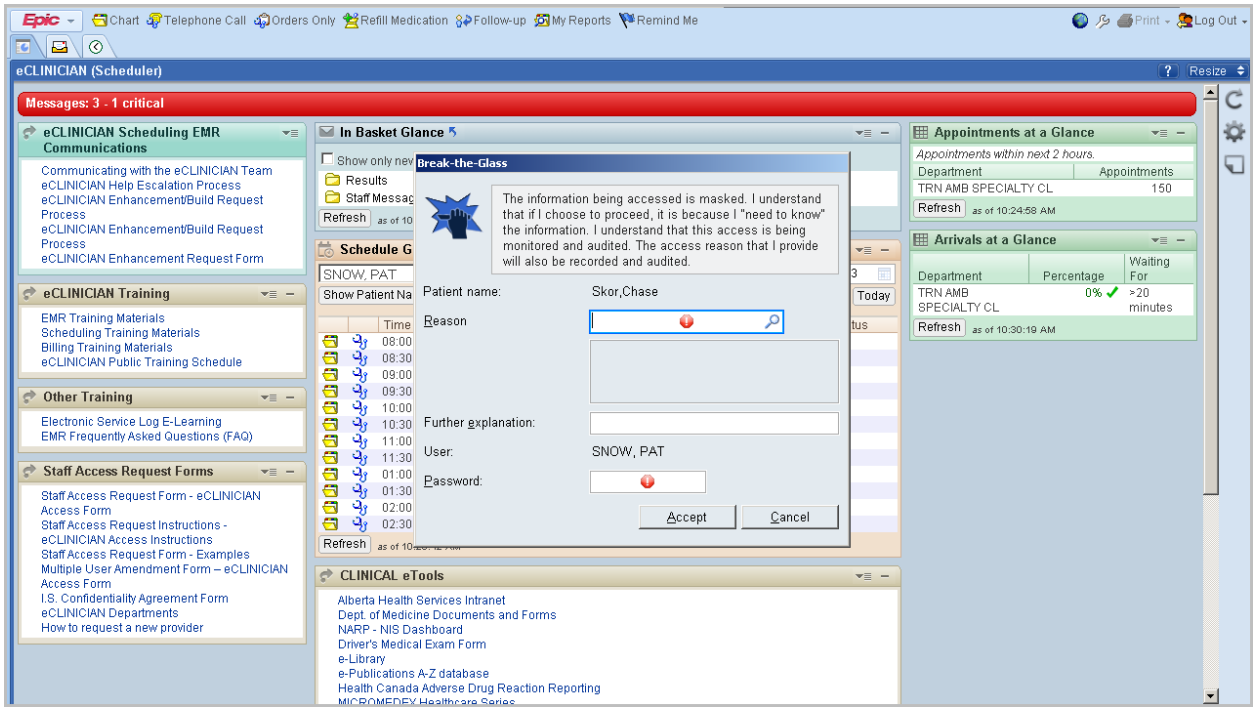
The role of the clinician is to counsel patients who seek this added confidentiality on their information, and to have the patient complete and sign the necessary forms, and to submit these forms to a central location. This process is further described in the ***Global Masking of a Patient's Record in e*CLINICIAN** Self Learning document.

Once a mask is applied, physicians and staff who need to access the record in order to provide care must lift the mask or ***break the glass***.

The mask is set in the AHS Client Registry (formerly called the Enterprise Master Person Index, or EMPI) and applies only to ***e*CLINICIAN** and to Alberta Netcare.

BREAK THE GLASS

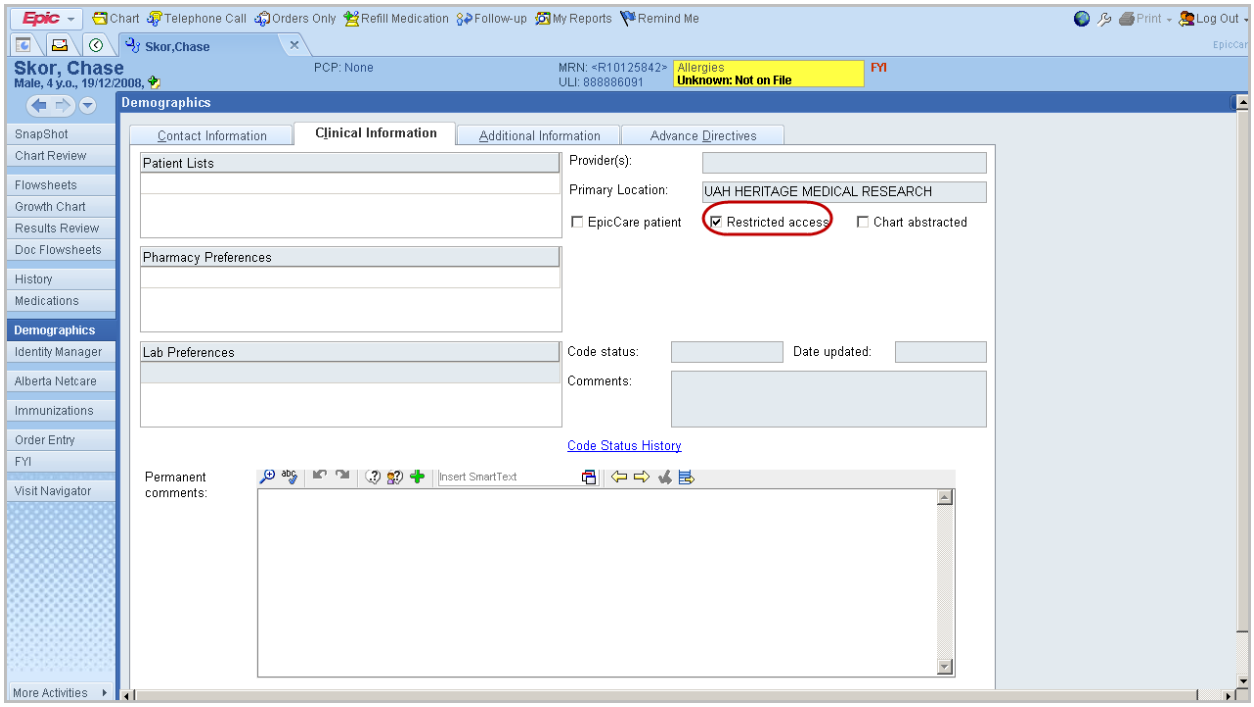
Once a mask is set, ***e*CLINICIAN** users will see the following Break the Glass window when they try to access the record of a masked patient.



To ***break the glass*** the user must select a reason and enter his or her ***e*CLINICIAN** password.

Note that when a record is unmasked, the unmasking is logged electronically and is subject to daily audits.

Once the record is unmasked the only visual indicator for the user that the record is masked appears on the Clinical Information tab of the Demographics activity.



BREAK THE GLASS EXCEPTIONS

Since ***break the glass*** can create inconvenience and delays when users must frequently access a record for appointment scheduling or managing a scheduled encounter, the following exceptions are built into the system.

The user will **not** be required to ***break the glass*** when:

- he/she has broken the glass in the last 7 days
- he/she is the patient's encounter provider and has an encounter scheduled with that patient in the next 15 day
- he/she is the patient's encounter provider and had an encounter scheduled with that patient in the last 15 days.

REVIEW BASIC PATIENT INFORMATION

Activities like Snapshot and Chart Review help you to quickly review significant history, current medications, allergies, documentation from past appointments as well as previous test results.

REVIEW THE SNAPSHOT

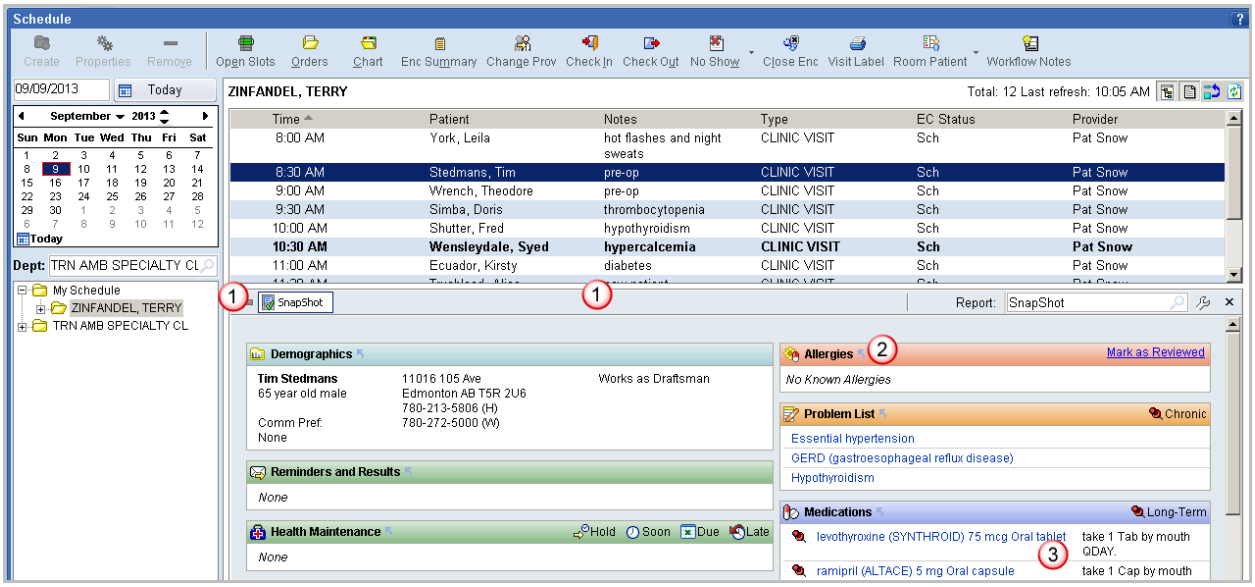
The Snapshot is a great way to get a quick summary of clinically relevant information about the patient. You can quickly be reminded of the patient's basic demographics, medications, medical problems and allergies.

When you think ***SnapShot***, think ***hyperlinks***. The data in each section is formatted as a hyperlink. Depending on what the hyperlink is for, you can click to open a report or to open a form that displays more information.

① The SnapShot is the default report in the lower right-hand pane of the Schedule activity.

② A section heading with a blue arrow after its name, such as Allergies, opens an activity where you can review additional information about that topic.

③ The items listed in sections like Allergies or Medications are also hyperlinks. Click to view more information about each item.



TIP: The SnapShot also displays as an activity in the patient's chart as well as a report in the NoteWriter activity.

REVIEW THE PATIENT HEADER

The Patient Header displays at the top of the patient's workspace and displays basic patient information such as name, alert flags (FYIs), MRN, date of birth, age, sex, allergies, and primary care provider (PCP).

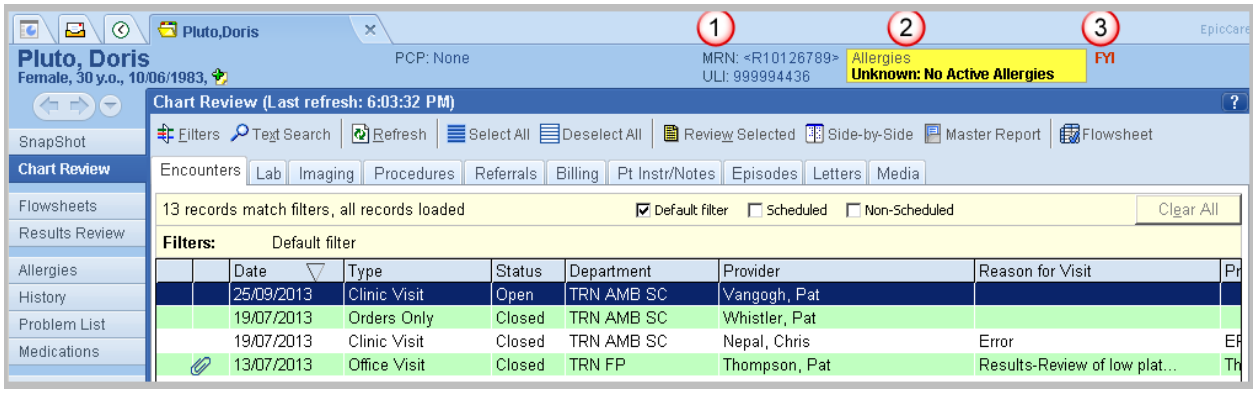
① **MRN, PHN/ULI**: The MRN represents the active MRN for the patient based on the department you are logged to. For private family practice clinics, the patient's PHN/ULI displays in this field

② **ALLERGIES**: For allergies, the Patient Header displays one of the following:

- Unknown: Not on File (allergies have never been reviewed)
- Unknown: No Active Allergies (previously documented allergies have been deleted)
- No Known Allergies (patient reports no allergies)
- Name of the allergies

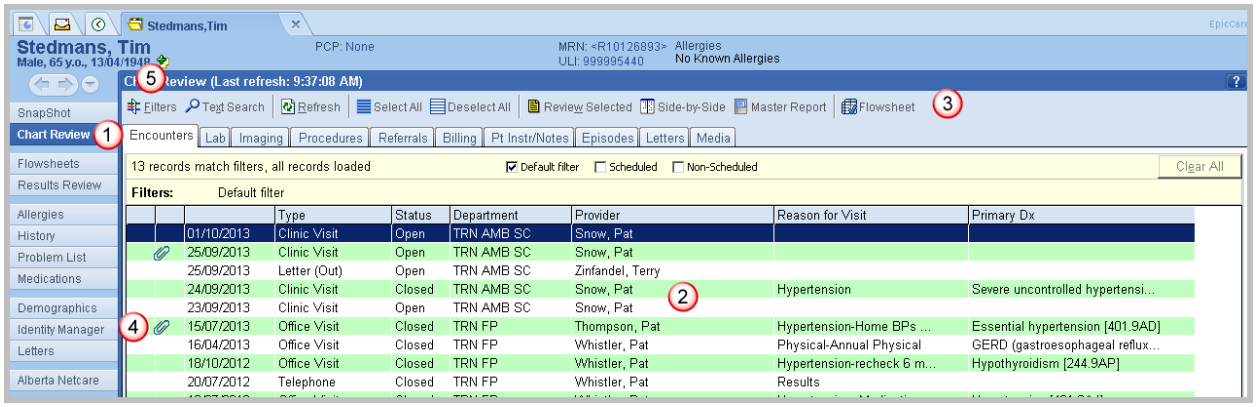
If there are more allergies than can be displayed in the allergy area of the patient header, three dots display at the end of the line. Click the link to see the complete list.

③ **FYI FLAGS**: Patient FYI flags represent alert notes that are associated with a patient's record.



REVIEW THE CHART REVIEW ACTIVITY

The Chart Review activity provides easy access to a large repository of information about the patient.



① **TABS**: This activity is made up of a series of tabs with each tab providing view-only access to specific information:

- Encounters: displays past visit information
- Lab: displays lab tests
- Imaging: displays diagnostic imaging reports
- Pt Instr/Notes: displays encounter progress notes and patient instruction notes. This tab also displays scanned Emergency Department Reports and transcriptions. To see the Progress notes, deselect Pt Instr checkbox.
- Referrals: displays referral information.
- Media: displays scanned documents. Keep in mind, if you scan, for example, an out of province lab report, the document is filed under the Media tab, ***not*** the Lab tab.

② **ROWS**: Each tab contains lines or rows of information. **Double-click** each row or line to view the details in a report.

> **TIP**: Refer to the personalization topic Customize Chart Review Reports to learn how to organize reports in a way that suits your needs.

③ **TAB TOOLBARS**: Each tab in Chart Review has its own toolbar which supports viewing the information within that tab. You can access tabs that don't fit in the toolbar by using the left/right arrows to view the far left/right tabs.

④ **PAPERCLIP ICON**: If there is an attachment to an encounter, order or medication, a blue paperclip displays beside the record. To find out what the attachment is (is it a scan? a dictation?) without opening the report, **right-click** the paperclip and select ***Additional Info***.

⑤ **FILTER**: All Chart Review tab toolbars have a **Filter** button which allows you to quickly focus on only those records you wish to view.

CLINICAL DATA AVAILABLE IN *e*CLINICIAN

***e*CLINICIAN** contains clinical data from a variety of sources primarily in the Edmonton zone. The information provided is a direct feed from the same source(s) populating Alberta NetCare.

If you are seeing a patient from outside of the Edmonton zone, or you are not seeing expected results or reports for any patient in ***e*CLINICIAN**, you should refer to Netcare.

The ***e*CLINICIAN - EMR** patient chart contains clinical data from the sources listed in the table below.

Data Source	Date Available	Results Back To	Name of Chart Review Activity Tab
Lab Data			
AHS facilities			
• Edmonton area (All Facilities)	15 Apr 08	01 Jan 06	Lab
• North zone (Northern Lights)	15 Apr 08	01 Jan 06	Lab
Provincial			
• Provincial Lab (Edmonton zone)	01 May 08	01 May 08	Lab
• Provincial Lab (Province Wide)	19 July 12	19 July 12	Lab
• Newborn Metabolic Screening	01 June 08	01 June 06	Lab
Cross Cancer Institute	28 Jun 10	28 Jun 10	Lab
DynaLIFE (formerly DKML) collection sites Edmonton and area Central: Red Deer, Lloydminster, & Smith Clinic Camrose (where tests are performed at Dynalife Edmonton Main Lab)	15 Apr 08	01 Jan 06	Lab
Electrodiagnostics (ECG)			
All AHS Edmonton and area facilities • ECG PDFs	15 Apr 08	Feb 07	Lab

Data Source	Date Available	Results Back To	Name of Chart Review Activity Tab
Transcribed Reports			
All AHS Edmonton facilities • Operative Report • Progress Report/Clinic Report • Discharge Summary • Home Care Summary • Consultation • History • Letter • Neurophysiology (EEGs) • Cardio diagnostic • Emergency Dept Reports (scanned)	15 Apr 08	01 Jan 06	Notes
Diagnostic Imaging Text Reports			
All AHS Edmonton facilities (Text)	15 Apr 08	01 Jan 06	Imaging
Medical Imaging Consultants (MIC) – Edmonton zone (PDF)	15 Apr 08	15 Apr 08	Imaging
Insight Medical Imaging (IMI) – Edmonton zone (Text)	15 Apr 08	15 Apr 08	Imaging
CML Healthcare – Edmonton zone (PDF)	15 Oct 08	15 Oct 08	Imaging
Endoworks Reports			
RAH and UAH sites Procedure Notes – "Colorectal Cancer Screening – CRC" exam procedure report	04 April 13	01 Jan 06	Procedures

To view patient data prior to the listed dates you must to use Alberta Netcare or other paper sources. Results from sources not listed above, need to be viewed in Alberta Netcare. For information on **data not available** in ***e*CLINICIAN**, refer to the section: **Clinical Data NOT Available in *e*CLINICIAN**.

CLINICAL DATA NOT AVAILABLE IN eCLINICIAN

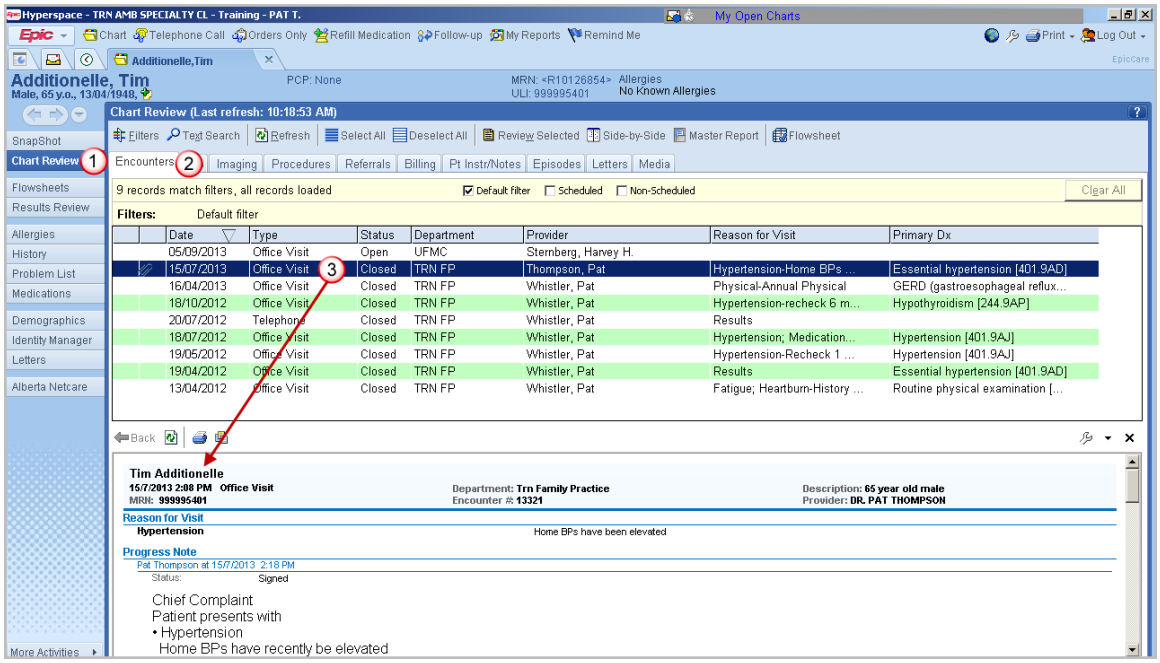
While ***e*CLINICIAN - EMR** is a shared EMR with access to clinical data from a variety of locations, it does not contain the entirety of a patient's medical record. You must also use Alberta Netcare or paper charts to view this type of information.

The ***e*CLINICIAN - EMR** patient chart ***DOES NOT*** contain clinical data from the sources listed in the table below.

Lab Results
• AHS -Calgary (All Facilities) • AHS - Cancer Tom Baker Centre Calgary • AHS - Central (All Facilities) • AHS - South (All Facilities) • Canadian Blood Services • HLA Lab Results
Diagnostic Imaging
• Amiha Diagnostic Imaging (St. Albert) • Breast Centre Radiology • Canada Diagnostic Centres (CDC) – Westgate X-Ray and Ultrasound • Cross Cancer Institute • Devon X-Ray Clinic • Dr. J.P. Mayo • Edmonton Cardiology Consultants at UAH and RAH - Echocardiograms • Glenwood Radiology • Pureform Diagnostic Imaging Clinic – includes Echocardiography (Sherwood Park) • The X-Ray Clinic at Northgate Centre • The X-Ray Clinic at 124th Street • The X-Ray Clinic at 142nd Street DI results from ALL facilities outside Edmonton and area are ***NOT*** found in ***e*CLINICIAN**.
Electrodiagnostics
• PDF Files: o Heart Diagram o MAHI Stress and Holter Tests o Paceart
Other Results
• AHS Edmonton - Tuberculin Skin Tests • Immunizations Community Clinic

VIEW PAST VISIT INFORMATION

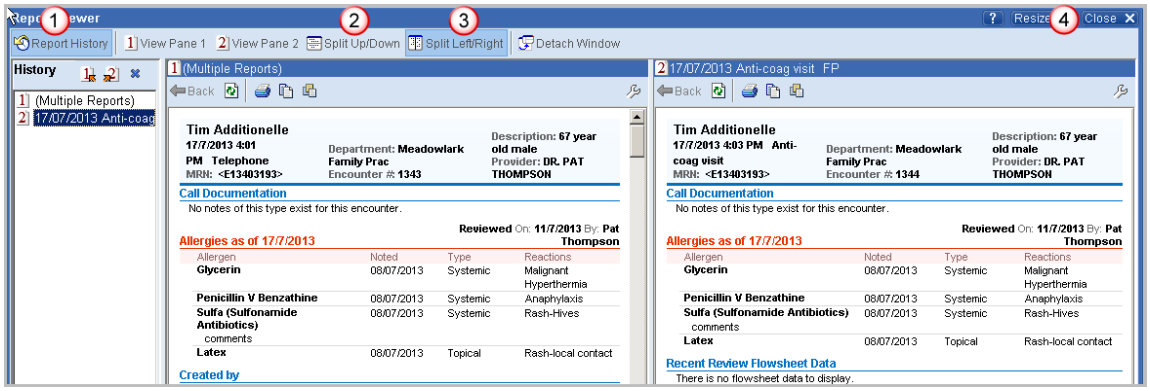
1. From the left-hand side of the patient's workspace, select the Chart Review activity.
2. To review the patient's past visits, select the Encounters tab.
3. Click the row for an encounter and view the report in the lower pane. **Double-click** the row to see the report in an expanded view.



TIP 1: If the report does not display, **right-click** the selected row and select **Preview**. Another option is to **right-click** and select **Display in Chart Sidebar**.

TIP 2: You can see Chart Review reports side-by-side. Click **Side-by-Side** on the tab toolbar.

The Report Viewer window displays.



Notice these features:

① Report History Pane

② Split Up/Down view

③ Split Left/Right view (shown)

④ Close button in the upper right corner of the window, which return you to the default view.

The **Default filter** on the Encounters tab is set up to show you encounters related to patient interactions. These include Clinic, Office, Refill, Telephone, Orders Only and Letter encounters.

Important Information about the Encounter Tab

The Encounters tab also contains reports for data that does not actually involve a patient interacting with a provider. These types of reports are filtered out by the Default filter and include transcribed reports, DI Reports and Lab Reports.

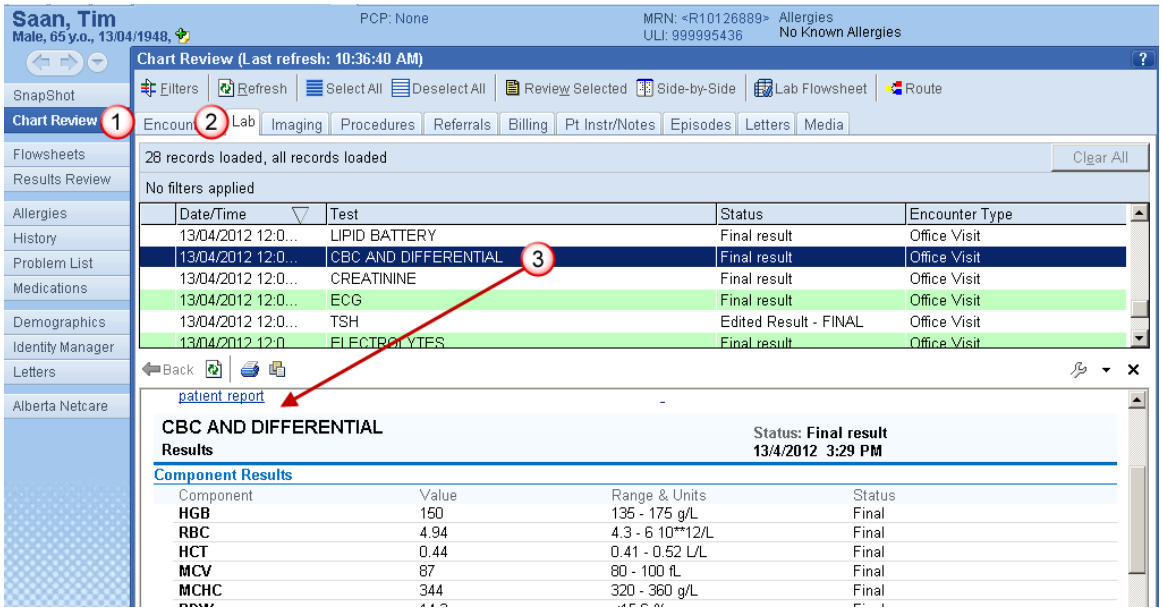
It is strongly recommended that you do not attempt to view this type of information by deselecting the Default filter and drilling down through reports.

This type of information is best viewed by going directly to tabs such as the Lab and Notes which will be accurate and up-to-date.

To view which Chart Review displays these data reports, refer to the topic Clinical Data Available in ***e*CLINICIAN**.

VIEW LAB RESULTS IN REPORT FORMAT

1. From the left-hand side of the patient's workspace, select the Chart Review activity.
2. Select the Lab tab.
3. Click the row for that result and view the report in the lower pane. **Double-click** the row to see the report in an expanded view.



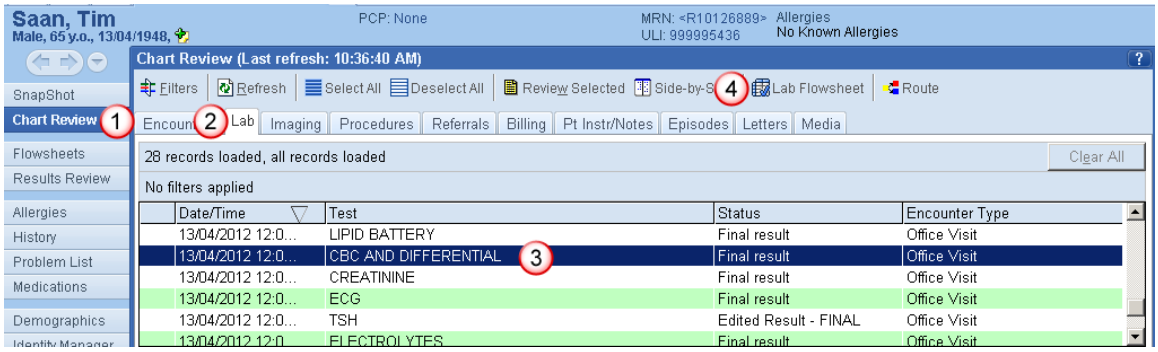
TIP: Abnormal results are highlighted in yellow on the Result Report.

VIEW LAB RESULTS IN FLOWSHEET FORMAT

1. From the left-hand side of the patient's workspace, select the Chart Review activity.
2. Select the Lab tab.
3. To view the lab result in flowsheet format, select the appropriate order.

   TIP 1: You can also select multiple orders by holding down the **CTRL** key as you make your selections.

4. From the toolbar, click **Lab Flowsheet**. The Laboratory Results window opens, displaying result components in a chart format.



5. To close the Lab Flowsheet, on the top right-hand corner of the window, click **Close.**

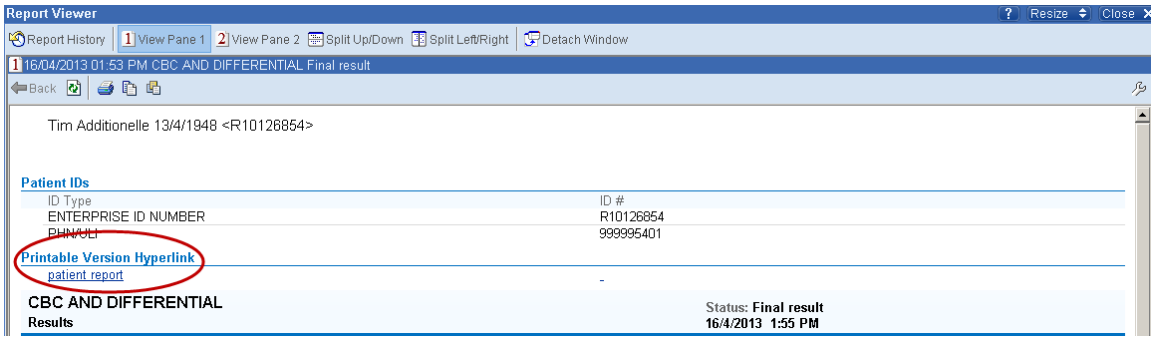
Results that display in a narrative format should not be selected for display in a lab flowsheet format. You must view the results in report format.

PRINT RESULTS

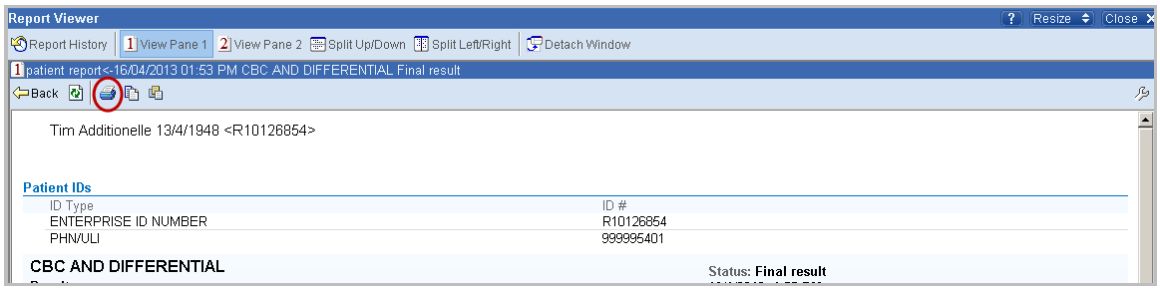
The steps for printing results depend on which view you use to review the results.

REPORT FORMAT

1. With the Result report displayed, locate the Printable Version Hyperlink section.
2. For a condensed version of the report, click the ***patient report*** hyperlink.

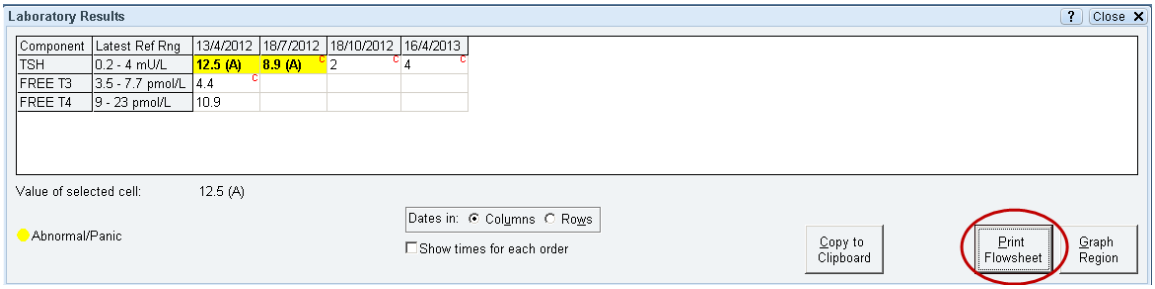


3. On the patient report toolbar click the **Printer** icon.



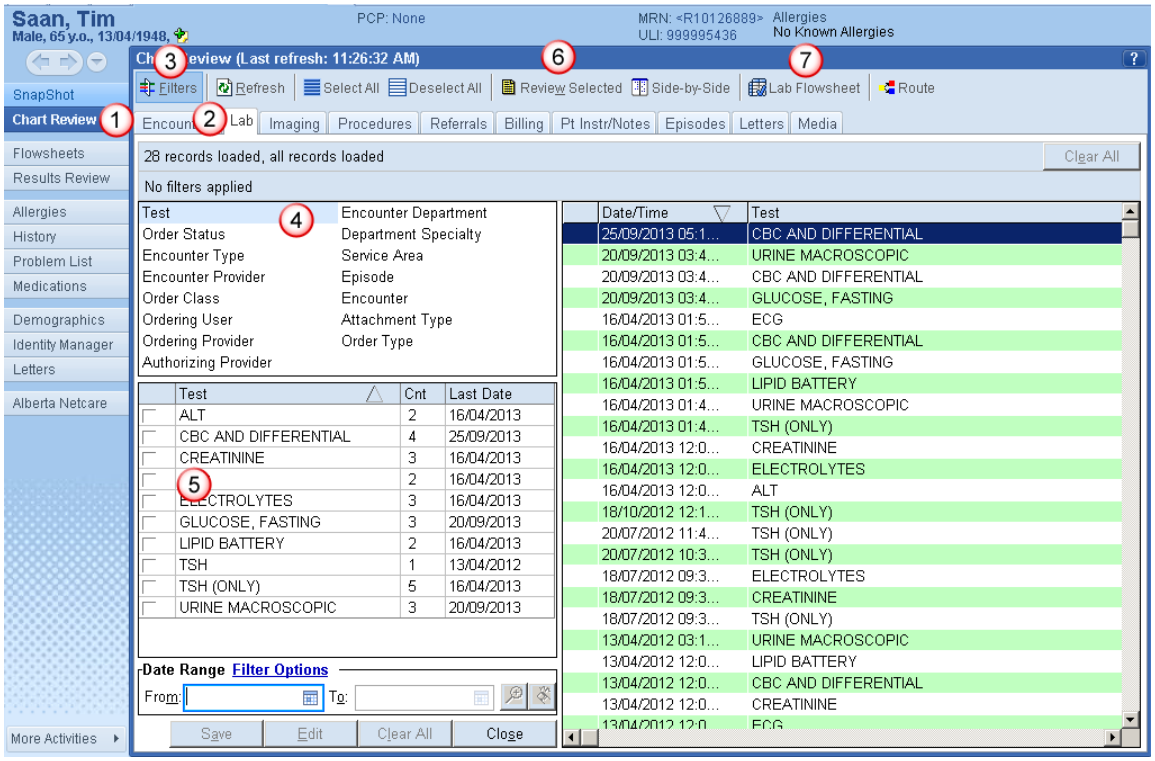
FLOWSHEET FORMAT

1. With the Laboratory Results flowsheet displayed, click **Print Flowsheet**.


Laboratory Results
Close
Component | Latest Ref Rng | 13/4/2012 | 18/7/2012 | 18/10/2012 | 16/4/2013
TSH | 0.2 - 4 mU/L | 12.5 (A) | 8.9 (A) | 2 | 4
FREE T3 | 3.5 - 7.7 pmol/L | 4.4
FREE T4 | 9 - 23 pmol/L | 10.9
Value of selected cell: 12.5 (A)
Abnormal/Panic
Dates in: Columns Rows
Show times for each order
Copy to Clipboard
Print Flowsheet
Graph Region

FILTER RESULTS

You can filter results to see the ones that are the most meaningful to you.



1. From the left-hand side of the patient's workspace, select the Chart Review activity.
2. Select the Lab tab.
3. From the toolbar, click **Filters**. In the upper left-hand pane, a list of filter categories displays. In the right-hand pane, the results available for the patient display.
4. Select one of these categories (e.g. ***Test***). In the lower left pane, a list of patient-specific entries belonging to that category display with checkboxes.

5. Select as many checkboxes as you need to refine your filter. As you make your selections, the listeof results in the right-hand pane gets smaller, displaying only those results matching your search criteria.

   TIP 1: You can create complex filters by selecting more than one category. For example, you can filter once on all of the tests for a particular provider and then filter again on all of their encounters where there was a particular diagnosis. Simply repeat **steps 4 and 5** for each category you want to add to your filter.

6. To view the filtered lab results in report format, click **Review Selected**.
7. To view the filtered lab result in flowsheet format, click **Lab Flowsheet**.

   TIP 2: You can also filter using the From and To 'date' fields at the bottom of the **Filter** window.

   TIP 3: You can save filters for future use. Refer to the **Personalize *e*CLINICIAN** section.

More on Filters

- Filters **display in the order** that they were created. To change the order of the display you must delete the appropriate filters and recreate them in the appropriate display order.
- Keep **filter names short** as this allows more filters to display on the filter bar. When you create more filters than can display on the bar you must click the **>>** button (at the end of the filter bar) to see any remaining filters.

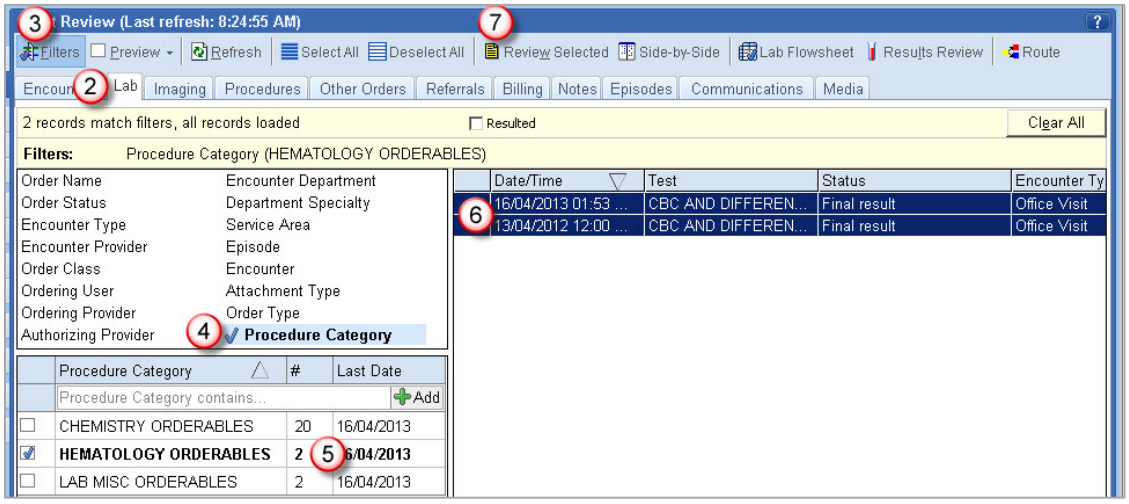
VIEW LABORATORY RESULTS

One way to view laboratory results is to filter using the ***Procedure Category*** (e.g. Chemistry Orderables, Hematology Orderables, Serology Orderables).

1. From the left-hand side of the patient's workspace, select the Chart Review activity.
2. Select the Lab tab.
3. From the toolbar, click **Filters**. In the upper left-hand pane, a list of filter categories displays. In the right-hand pane, the results available for the patient display.
4. Select ***Procedure Category***. In the lower left pane, a list of entries belonging to that category display with checkboxes.
5. Select the procedure categories of interest.
6. The pane on the right-hand side displays the filtered list.

Since laboratory results are sent as narrative reports they should be viewed using only the report format.

7. Select the appropriate order(s) and click **Review Selected**.

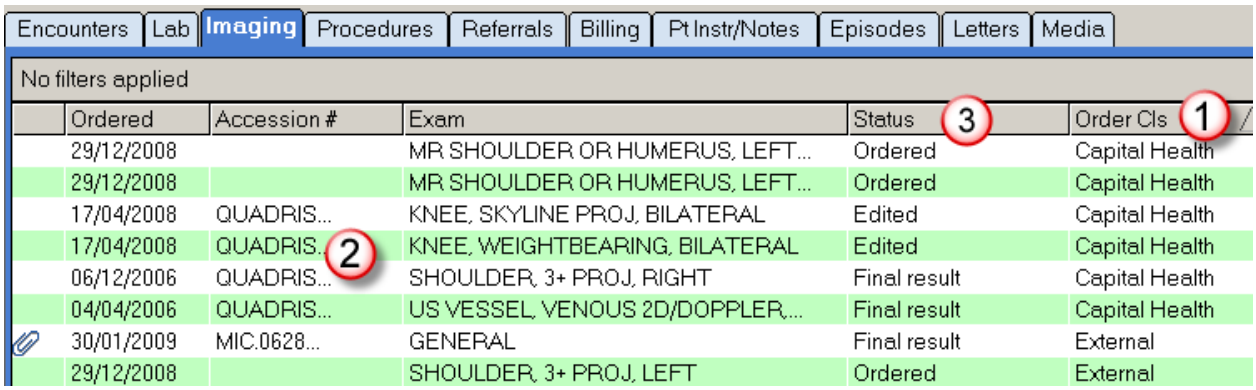


ADDITIONAL INFORMATION ON DIAGNOSTIC IMAGING RESULTS

① **ORDER CLASS**: Diagnostic imaging results sent to ***e*CLINICIAN** are categorized by order class.

② **ACCESSION # PREFIX:** This is one way you can identify the diagnostic imaging source.

③ **STATUS:** Diagnostic imaging results can have the following statuses: Ordered, Preliminary, Edited, Cancelled and Final Result. There may be times when the test you ordered and the test that is resulted do not have the same exam (test) name. In this case, the test you originally ordered remains listed with a status of **Ordered**.

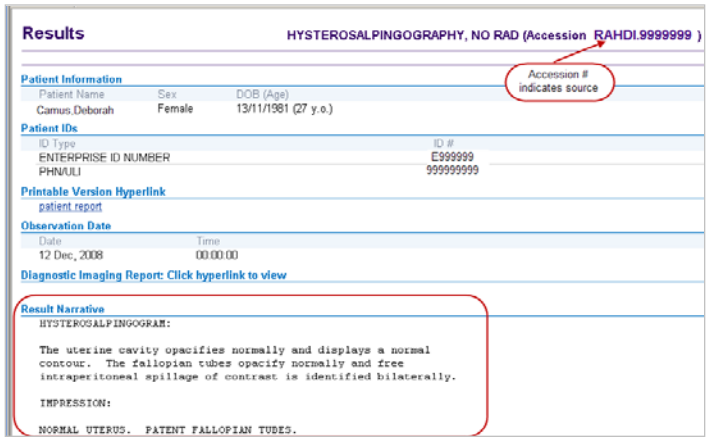


At the present time ***e*CLINICIAN** contains only narrative diagnostic imaging reports or PDF images of diagnostic imaging narrative reports. The diagnostic images themselves cannot be viewed. Use Alberta Netcare to review the images.

Each order class contains results from the indicated sources:

- Internal (Alberta Health Services – Edmonton zone)
  - RAHDI (Royal Alexandra)
  - UAHDI (University of Alberta)
  - QUADRIS
  - AGFA

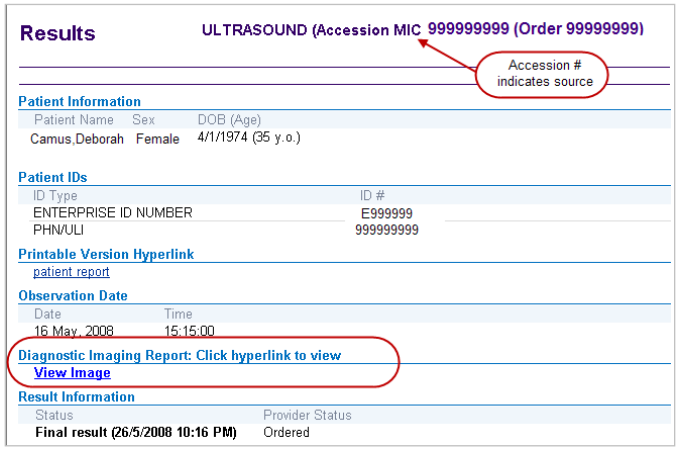
These results display as a ***result narrative***.


Results
HYSTEROSALPINGOGRAPHY, NO RAD (Accession RAHDI.9999999)
Accession # indicates source
Patient Information
Patient Name Sex DOB (Age)
Camus,Deborah Female 13/11/1981 (27 y.o.)
Patient IDs
ID Type ID #
ENTERPRISE ID NUMBER E999999
PHN/ULI 999999999
Printable Version Hyperlink
patient report
Observation Date
Date Time
12 Dec, 2008 00:00:00
Diagnostic Imaging Report: Click hyperlink to view
Result Narrative
HYSTEROSALPINGOGRAM:
The uterine cavity opacifies normally and displays a normal contour. The fallopian tubes opacify normally and free intraperitoneal spillage of contrast is identified bilaterally.
IMPRESSION:
NORMAL UTERUS. PATENT FALLOPIAN TUBES.

- External
  - IMI (Insight Medical Imaging)
  - MIC (Medical Imaging Consultants)
  - CML (CML Healthcare)

IMI results also display as a ***result narrative***.

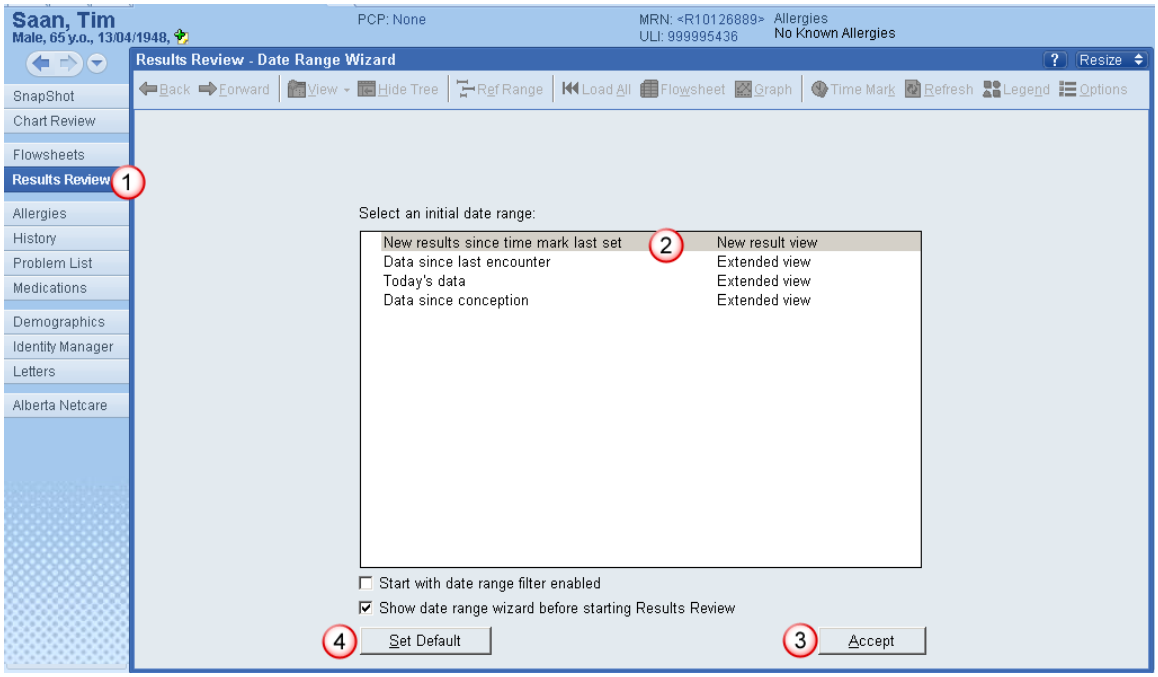
Results from MIC and CML are ***PDF images*** of a narrative report. To view the results click the View Image hyperlink.



VIEW LAB RESULT USING THE RESULTS REVIEW ACTIVITY

The Results Review activity is another place in ***e*CLINICIAN - EMR** where you can see a patient's lab results. The benefit of using the Results Review activity is that you can isolate the patient's lab results from the other information in Chart Review.

1. From the left-hand side of the patient's workspace, select the Results Review activity. The Results Review - Date Range Wizard displays.
2. Select a date option.
3. Click **Accept**. The Results Review window displays showing all of the patient's lab results since the timeframe you indicated on the Date Range Wizard.
4. To keep your Date Range Wizard selections as the default selection, click **Set Default**.



Results Review Toolbar

Ref Range button: Used to display reference ranges (the range of values considered normal for a test result) and the unit of measurement used when measuring that component. Click it again to hide this column.

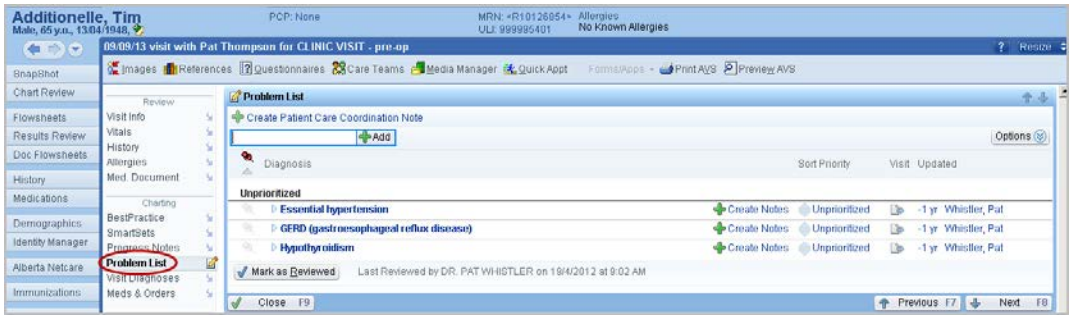
A different but quicker way to see a reference range is to hover your mouse over a result value. The reference range information and order number displays along the bottom of the activity.

Time Mark button: Allows you to flag the results as being viewed by you at the current date and time. One of the Date Range Wizard options is to show **New results since time mark last set**. The next time you open the Results Review activity, ***e*CLINICIAN - EMR** will show you only the new results since the last **time mark**. Clicking this button also removes the italic formatting from the result values (and results are easier to read).

REVIEW THE PATIENT'S MEDICAL PROBLEMS

In ***e*CLINICIAN - EMR**, a problem is defined as a medical condition that is persistent across a number of encounters (i.e., not identified and resolved in a single ambulatory encounter).

When the chart is in documentation mode, the problem list displays as a navigator section.



In review mode, it displays as its own activity.

The features of the activity and the section are the same.

1. Access the Problem List activity.
2. To view additional information about a problem, click the problem hyperlink. The Details and Create Overview subsections display.

> **TIP**: For information on how you can customize the display of the Problem List activity, refer to the **Personalize *e*CLINICIAN** section.

REVIEW THE MEDICATIONS ACTIVITY

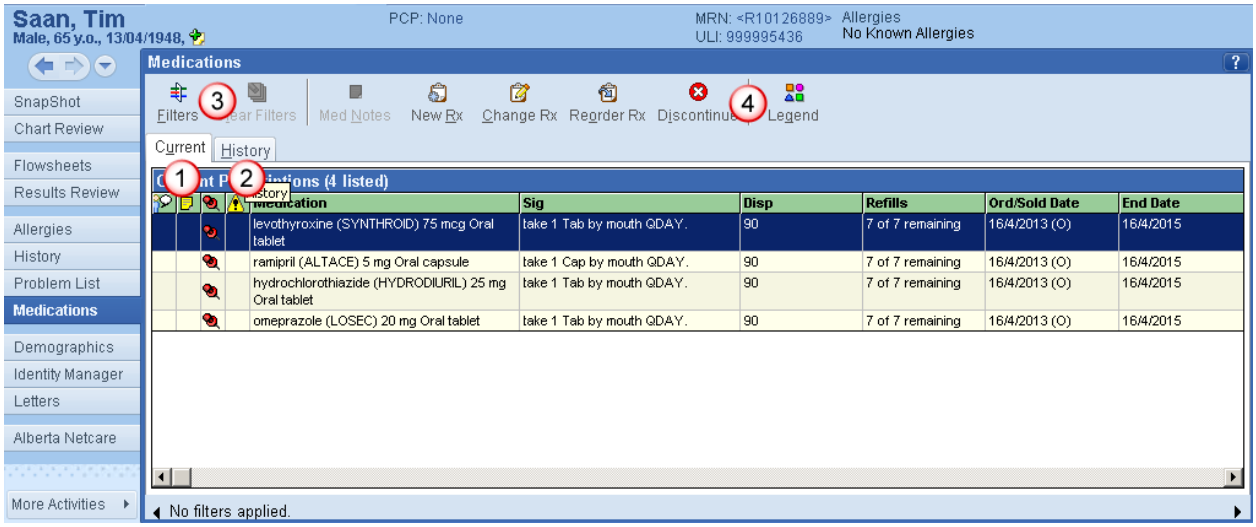
When in chart mode, the Medications activity provides you with a comprehensive review of the patient's medications.

① **CURRENT TAB**: This tab displays the medications that are prescribed as of right now. This includes medications that have a future end date as well as ones that have been marked as Long Term ( ). Medications that have been marked as Long Term remain on the Current tab even after the end date has passed.

② **HISTORY TAB**: This tab displays all of the patient's past and current medications.

③ **FILTER:** Found on the Medication activity toolbar, this button allows you to quickly narrow the search for a particular medication.

④ **LEGEND**: Found on the Medication activity toolbar, this button helps you quickly determine the meaning of the various icons used in this activity.



REVIEW INFORMATION USING THE FLOWSHEET ACTIVITY

The Flowsheet activity can also be an important tool in helping you trend patient information. Flowsheets allow you to review data from different parts of the patient's record, such as vital signs and lab results for diseases such as diabetes.

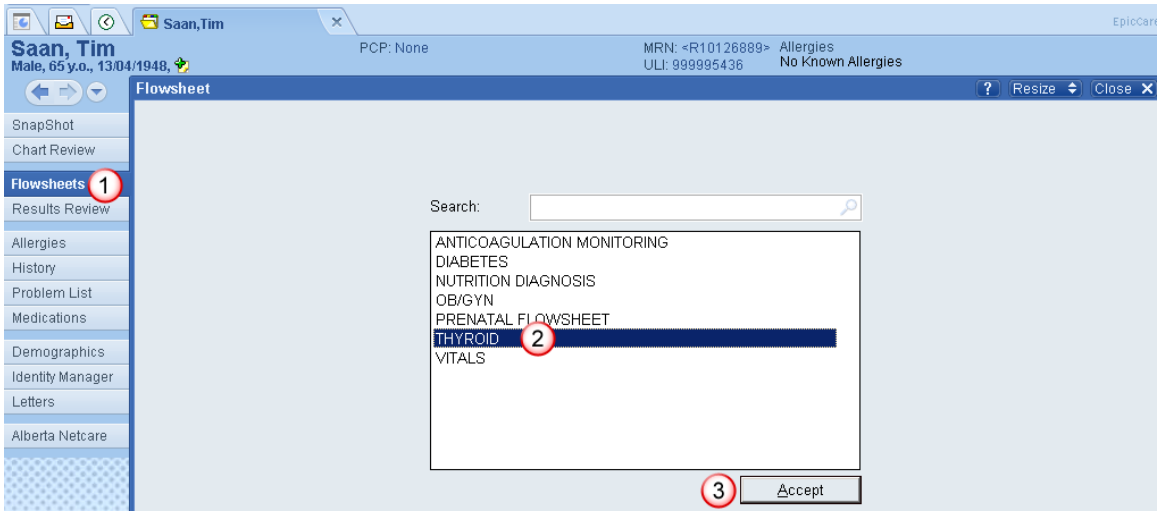
The ***e*CLINICIAN** team creates the flowsheets that display in this activity. They display as read-only information.

To view a flowsheet:

1. From the left-hand side of the patient's workspace, select the Flowsheets activity. The Flowsheet window displays a list of flowsheets applicable/designed for your speciality.

   TIP 1: Click the Selection tool next to the Search field to access all other available flowsheets.

2. Select the appropriate flowsheet form the list.
3. Click **Accept**.

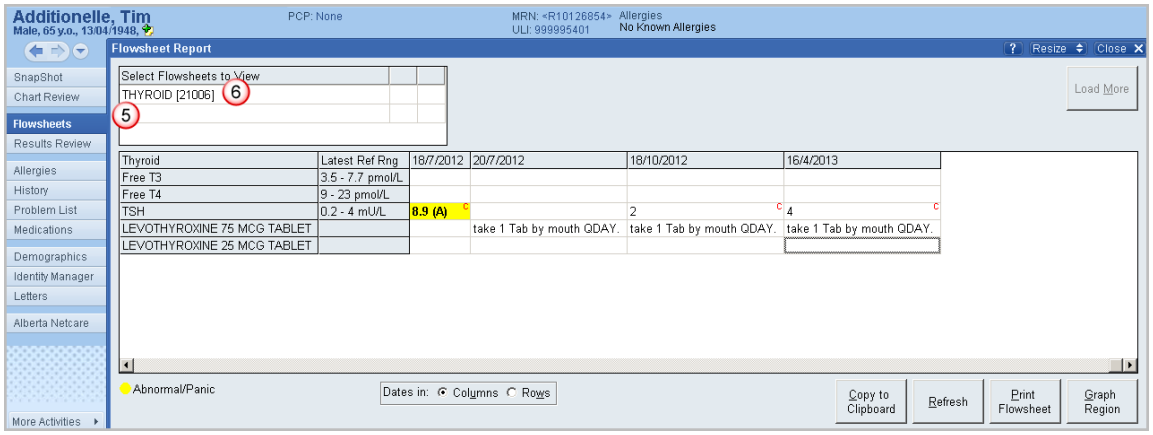


The Flowsheet report displays.

4. To add an additional flowsheet, in a blank cell under the **Select Flowsheets to View** area, click the **Selection** tool. A Record Select window displays all other available flowsheets.

   The additional flowsheet you choose displays below the current flowsheet.

5. To change the view to another flowsheet, in the cell currently displaying the flowsheet name, click the **Selection** tool. A Record Select window displays a list of flowsheets applicable/designed for your speciality.



6. To delete a flowsheet, click in the cell currently displaying the flowsheet name, and then press **DELETE**.

TIP 2: You can print the flowsheet as well as graph the data.

REVIEW INFORMATION WITH THE PATIENT

This chapter provides information about the most common tasks completed during the initial portion of the patient's visit.

The following main topics are covered in this chapter:

- Document Scheduled Encounters
- Review and Document Initial Details for the Visit
- Review and Update the Current Medication List
- Document Assessments
- Document Care Teams

DOCUMENT SCHEDULED ENCOUNTERS

Any interaction with or about a patient is documented in ***e*CLINICIAN - EMR** as an ***encounter***.

OPEN THE PATIENT ENCOUNTER

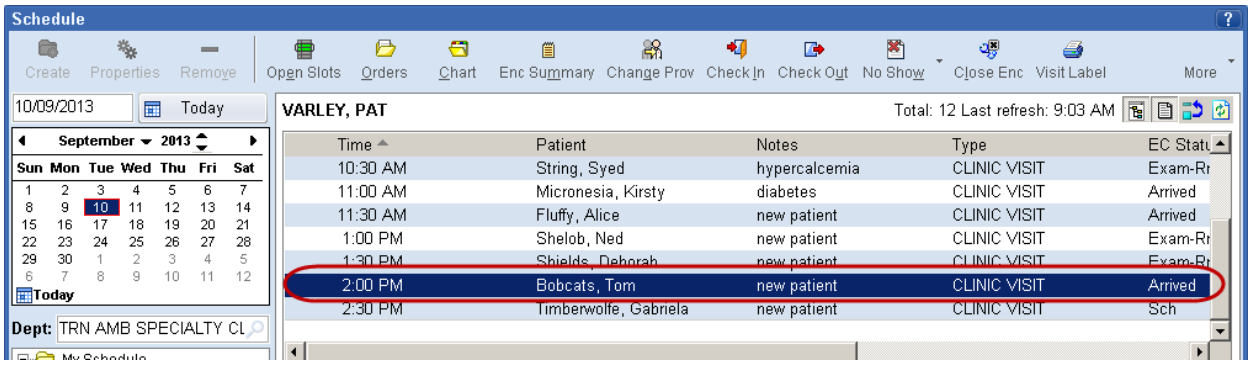
1. Access the Schedule activity.
2. Locate the patient's appointment in the upper right-hand section.
3. Verify that the EC status column shows that the patient has ***Arrived***.

EC Status

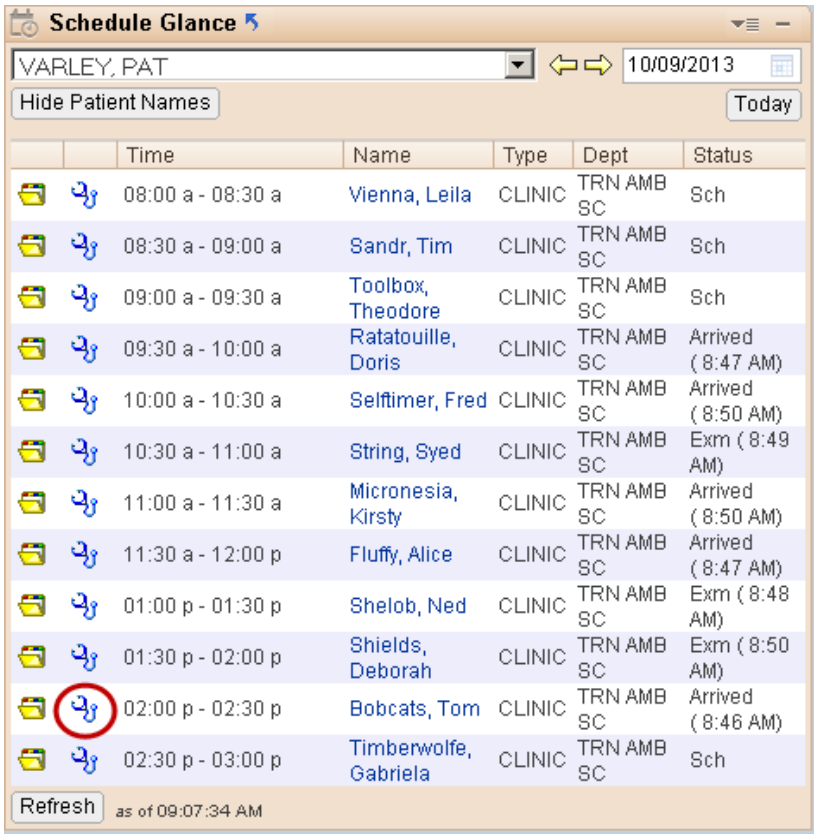
The EC Status conveys the stage of the patient's visit.

- Sch = Indicates that the patient is scheduled but hasn't yet arrived.
- Arrived = Indicates that the patient has arrived and has checked in. The patient can now be roomed.
- Exam-Rm = A provider has logged into the workstation in the indicated exam room and has starting documenting in the encounter.
- Comp = Patient has checked out but the encounter has not been closed (documentation incomplete).
- Closed: Comp = Patient has checked out and the encounter has been closed.

4. To open the encounter to begin charting, **double-click** the appointment.



Alternatively, if the patient is scheduled to see you (i.e., you are the encounter provider), you can use the Schedule Glance section on the ***e*CLINICIAN** Dashboard to begin documentation of your patient's visit. Click the ***Open the encounter*** (stethoscope) icon to the left of the patient's appointment to begin.



5. Once the patient's workspace opens, verify that you have opened the correct record by reviewing information in the Patient Header. Also note that a stethoscope icon displays on the workspace tab.

Secure the Workstation

If you need to leave the exam room after you have opened the encounter, you must secure the workstation before you leave.

You can secure the workstation by one of the following methods:

- Click the **Secure** button on the Hyperspace toolbar
- Select **Epic button > Secure**
- Click the drop down arrow next to Log Out and select **Secure**

This ensures that the patient's information is kept confidential and also bookmarks your place in the chart. When you return to the room, log in as usual. Hyperspace opens to the place where you were last working.

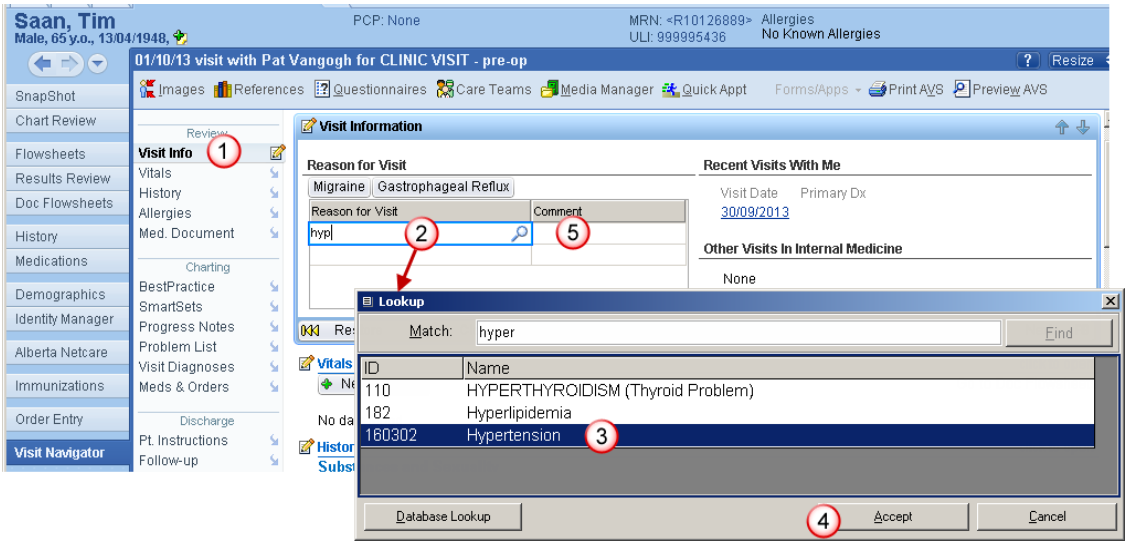
REVIEW AND DOCUMENT INITIAL DETAILS FOR THE VISIT

The initial portion of the patient's visit typically includes the documentation of the patient's reasons for visit and vitals, as well as the review and update of allergies, current medications and histories (substance, medical, surgical, family).

REASON FOR VISIT

The Reason for Visit represents the reason a patient has presented as described by themselves or the referring physician. The documentation of Visit Information is not required to close a scheduled encounter. For quality improvement, correct triggering of smartsets, BPAs and later reporting, it is very important for this information to be complete and verified by the physician.

1. From the Visit Navigator table of contents, access the Visit Info section. The Visit Information section displays in edit mode.
2. In the **Reason for Visit** field, use completion matching to search for an appropriate reason. The Lookup window displays.
3. Select the appropriate complaint.
4. Click **Accept**.
5. If required, in the **Comment** field type additional information about the reason.



6. Repeat steps 2 -5 for each reason, if required.

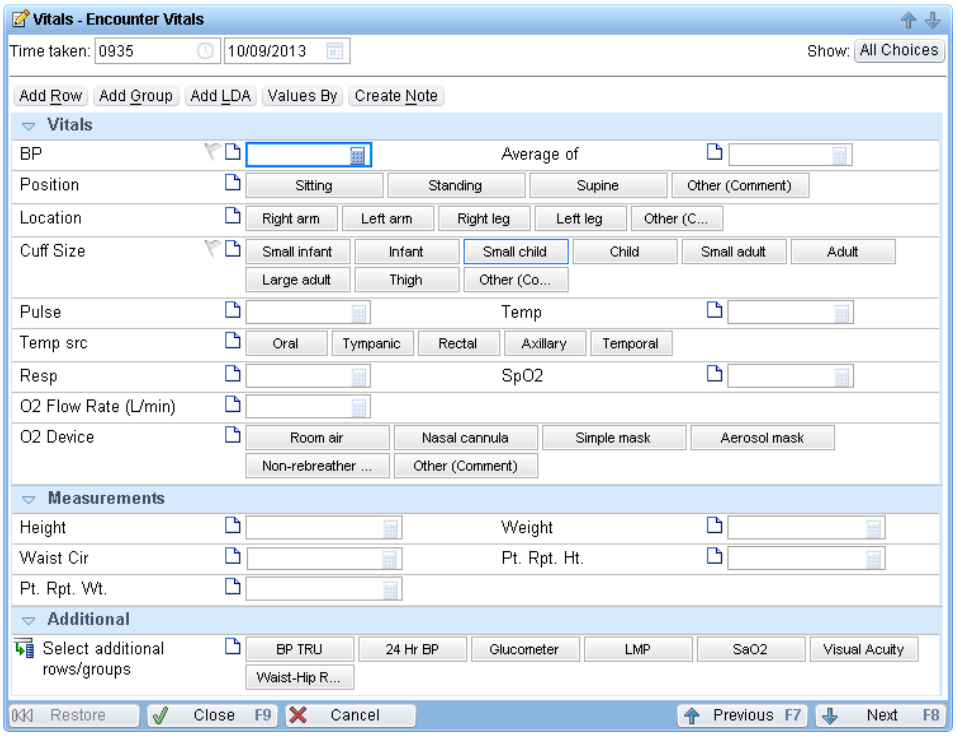
Users may click **Database Lookup** if the required reason is not located.

RECORD PATIENT VITALS

The patient vitals section of the visit navigator appears only within the context of scheduled encounters. This section does not appear in Orders Only, Refill Medication, or Telephone Call encounters.

1. From the Visit Navigator table of contents, access the Vitals section. The Vitals section displays in edit mode.
2. Record the vitals in the appropriate fields. For weight enter either the metric or imperial unit in the field.

   TIP: You can enter the height and weight in imperial units and ***e*CLINICIAN - EMR** converts the measurement to metric units.



3. Click **Close** when you are done. The navigator returns to read-only mode.

   When the Vitals section is in read-only mode (section is closed) you see a dual display of the imperial and metric values.

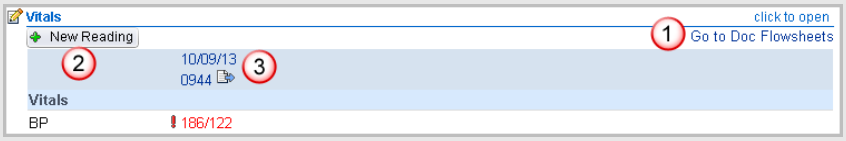
Measurements	
Height	172 cm (5' 7.72")
Weight	65.772 kg (145 lb)
Waist Cir	
Pt. Rpt. Ht.	
Pt. Rpt. Wt.	

More on Vitals - Features Available from the Read-Only mode

① You can record multiple readings of vitals within a single visit using the **Doc Flowsheet** hyperlink. The Doc Flowsheet activity displays.

② Alternatively, you can record multiple readings of vitals within a single visit by clicking the **New Reading** hyperlink. The Vitals navigator section reopens with a fresh set of fields in which you can document.

③ To edit the existing vitals, click the date/time hyperlink.



REVIEW AND UPDATE SUBSTANCE, MEDICAL AND SURGICAL HISTORY

The Visit Navigator History section allows you to review or update the patient's past history information, including: Substance, Medical, Surgical and Family.

1. From the Visit Navigator table of contents, access the History section. The History section displays in edit mode.
2. In the Substance History subsection, document the patient's Tobacco, Alcohol and Drug Use.

Alcohol/week Calculation

The amount of alcohol contained in an alcoholic beverage may vary. The calculation is based on a standard drink, which in Canada contains 13.6 grams or 0.5 oz of alcohol.

This is the amount in:

- 341 ml or 12 oz of beer or coolers (5% alcohol content)
- 142 ml or 5 oz glass of table wine (12% alcohol)
- 85 ml or 3 oz of fortified wine such as sherry or port (18% alcohol)
- 43 ml or 1.5 oz of spirits (40% alcohol)

Higher strength beer (e.g. 6, 7, or 8% beer), higher strength coolers and over proof liquor will contain more than 1 standard drink.

3. In the **Add an item** field in the Medical History or Surgical History sub-sections, use completion matching to search for a condition. The Medical or Surgical History - Details window displays.

Alternate way to add a Diagnosis/Procedure to Medical/Surgical History

You can quickly select a diagnosis or procedure to add to a patient's past medical or surgical history without using completion matching.

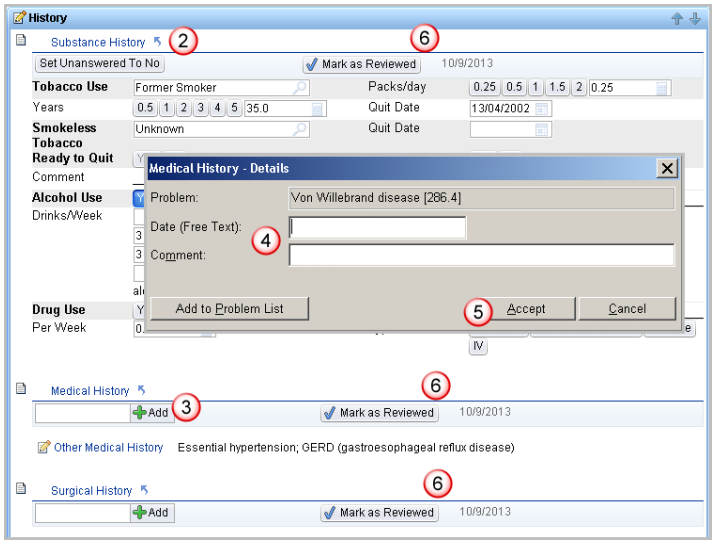
1. Without entering any text in the **Add an item** field, click the **Add** button. The Add Medical (or Surgical) History window displays.
2. From a list of folders that display on the left side of the window, select a category.
3. From the corresponding list on the right side of the window, select the appropriate diagnosis or procedure.
4. Click **Accept**.

4. If appropriate, document in the **Date** and **Comment** fields. If you have the appropriate security role you can also promote the medical condition to the patient's Problem List.
5. When you are done, click **Accept**. If you've used the **Add an item** field, then the condition is displayed under the Other Medical or Other Surgical History section.
6. For each section that you reviewed, click the corresponding **Mark as Reviewed** button. If you have reviewed all History subsections, click the **Mark as Reviewed** button in the lower left-hand corner of the History section.

Best Practice - Indicate Review of Current Findings

You'll see many places in the patient's chart where you can mark items as having been reviewed. By clicking **Mark as Reviewed** you stamp the record with your name and the current date and time.

This visual indicator makes it easier for subsequent providers to see the last time someone reviewed this information.



REVIEW AND UPDATE FAMILY HISTORY

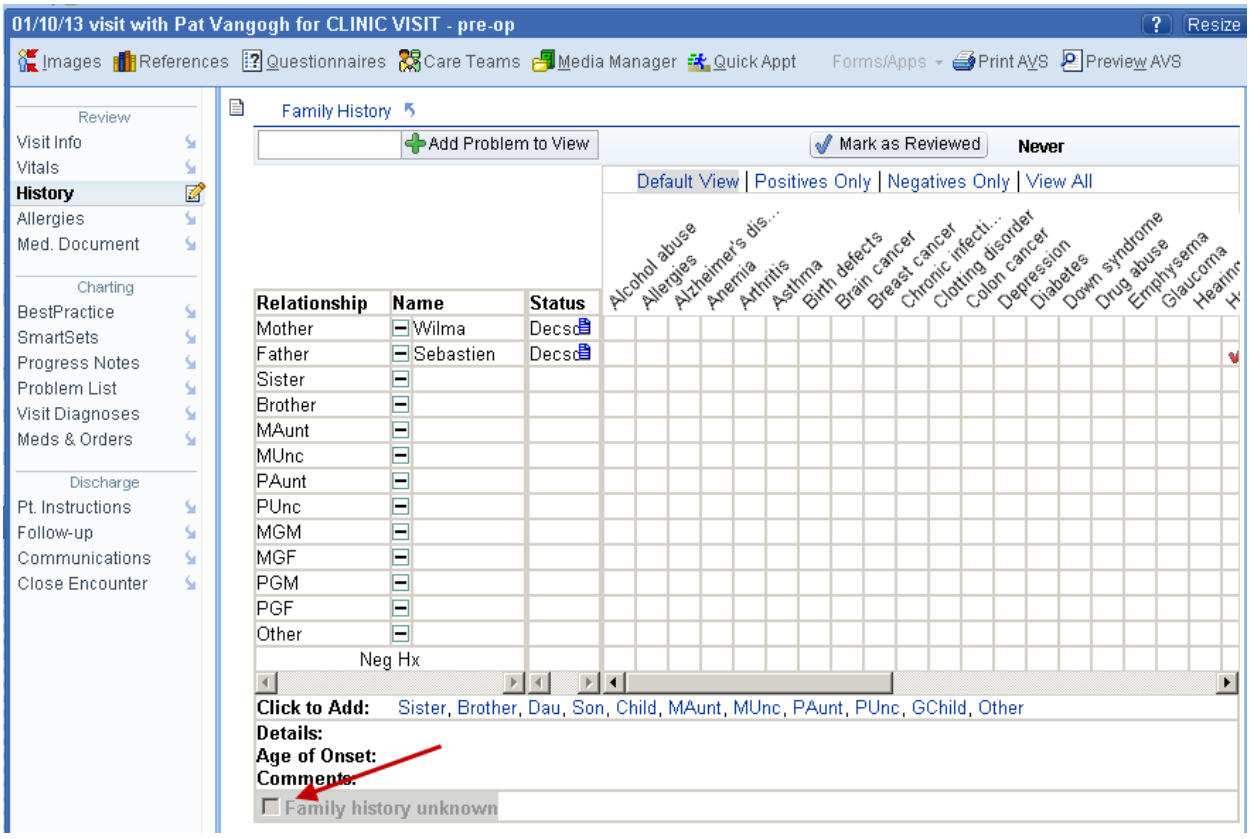
The Visit Navigator Family History sub-section allows you to quickly document the patient's family medical history, as well as the status of each family member.

Four different views are available in the Family History subsection: Default View, Positives Only, Negatives Only, View All. The Default View displays 40 common diseases/problems relating to multiple specialties.

Do NOT use **View All** view because ***e*CLINICIAN** attempts to load over 600 disease/problems into this sub-section and freezes Hyperspace for up to 60 seconds.

The steps for adding a disease/problem that does not display in the Default View are described below.

If the Family history is unknown, you can check the Family history unknown box.

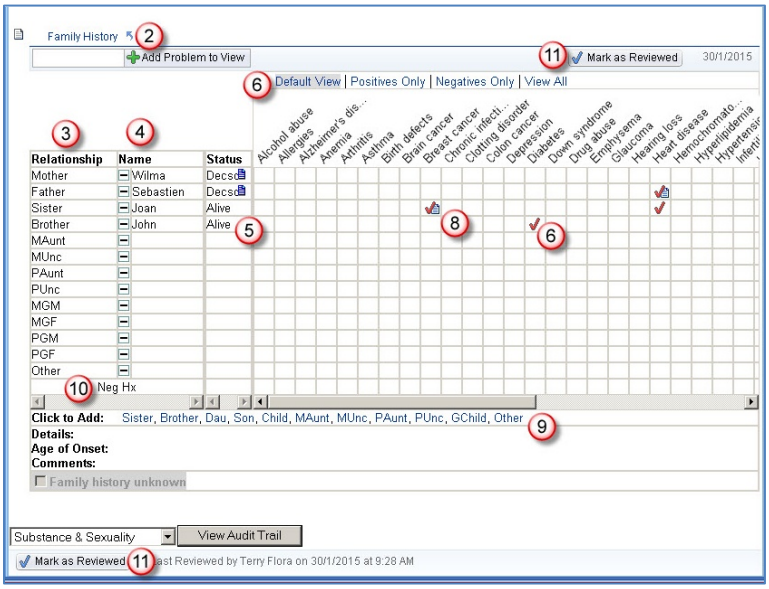


This topic is divided into two sections based on whether or not the disease/problem displays in the Default View.

DISEASE/PROBLEM DISPLAYS IN THE FAMILY HISTORY SUBSECTION'S DEFAULT VIEW

To document a disease/problem for a patient's family member when the disease/problem displays in the Default View, perform the following:

1. From the Visit Navigator table of contents, access the History section.
2. Scroll down to the Family History subsection.
3. For the first family member, select the appropriate Relationship row.
4. If known, type the relation's name and tab out of the field.
5. The **Status** field defaults to ***Alive***. This field acts as a toggle allowing you to select other statuses.
6. In the Default View, find the column for the medical condition/disease, and click the corresponding cell in the Relationship row. A red checkmark displays.
7. If required, **right-click** and add the age of onset or a comment.
8. Click **Accept**. A blue and white paper icon indicates that a comment has been entered. Hover your mouse over the icon to see the comment.
9. To add additional relations to the grid, select the appropriate hyperlink in the Click to Add area at the bottom of the grid.
10. If documenting a negative history is required, find the column for the medical condition/disease, and click the corresponding cell in the Neg Hx row.
11. When you are done, click the corresponding **Mark as Reviewed** button. If you have reviewed all History subsections, click the **Mark as Reviewed** button in the lower left-hand corner of the History section.



Best Practice - Indicate Review of Current Findings

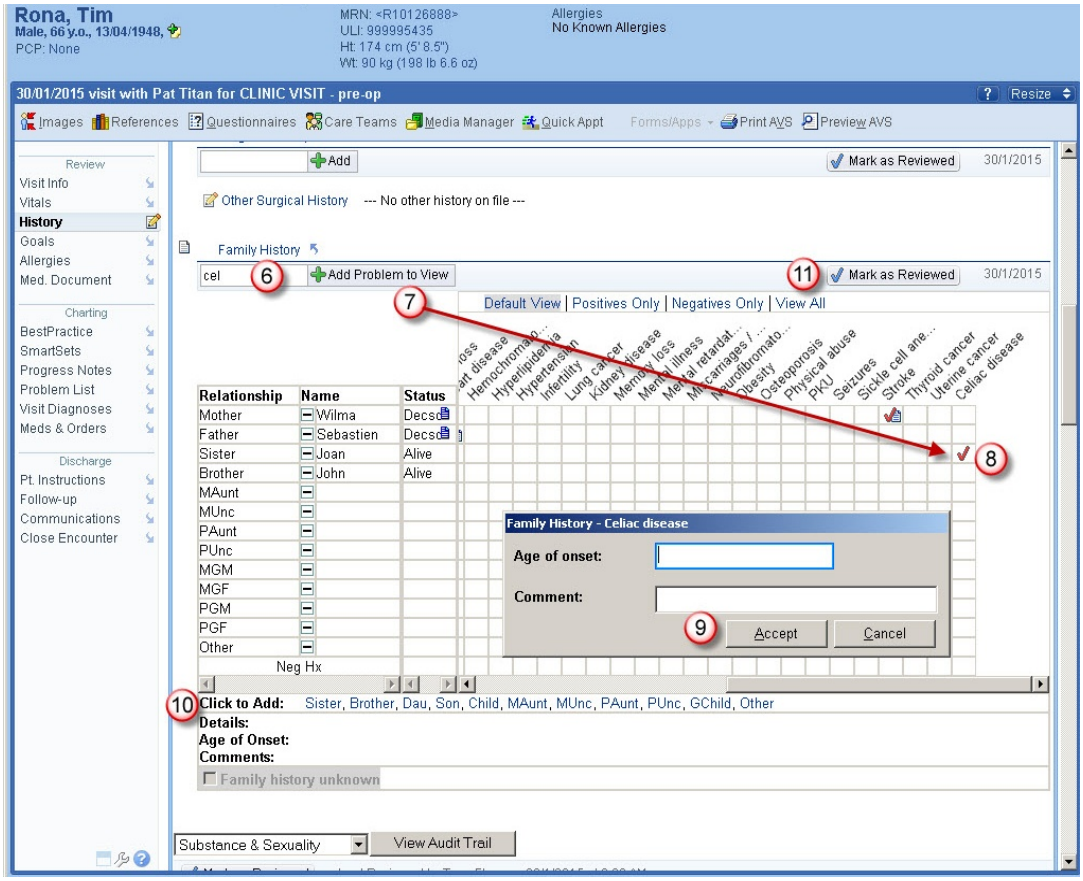
You'll see many places in the patient's chart where you can mark items as having been reviewed. By clicking **Mark as Reviewed** you stamp the record with your name and the current date and time.

This visual indicator makes it easier for subsequent providers to see the last time someone reviewed this information.

DISEASE/PROBLEM DOES NOT DISPLAY IN THE FAMILY HISTORY SUBSECTION'S DEFAULT VIEW

To document a disease/problem for a patient's family member when the disease/problem does not display in the Default View, you can add additional column(s) to the Family History grid.

1. From the Visit Navigator table of contents, access the History section.
2. Scroll down to the Family History subsection.
3. For the first family member, select the appropriate Relationship row.
4. If known, type the relation's name and tab out of the field.
5. The **Status** field defaults to ***Alive***. This field acts as a toggle allowing you to select other statuses.
6. In the **Add problem column to view** field, completion match on the medical problem
7. Click Add **Problem to View**. The column for the problem entered appears on the right-side of the grid, not alphabetically.
8. Under the new column, click the corresponding cell in the Relationship row. A red checkmark displays.
9. If required, **right-click** and add a comment and then click **Accept**. A blue and white paper icon indicates that a comment has been entered. Hover your mouse over the icon to see the comment.
10. To add additional relations to the grid, select the appropriate hyperlink in the Click to Add area at the bottom of the grid.
11. When you are done, click the corresponding **Mark as Reviewed** button. If you have reviewed all History subsections, click the **Mark as Reviewed** button in the lower left-hand corner of the History section.



Best Practice - Indicate Review of Current Findings

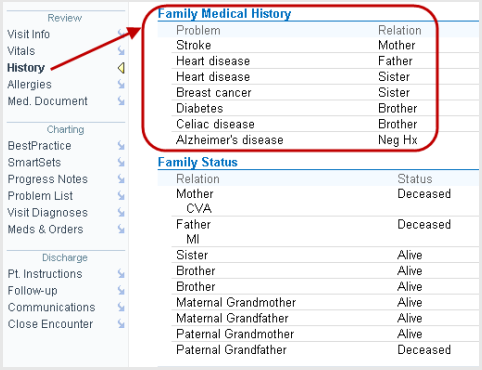
You'll see many places in the patient's chart where you can mark items as having been reviewed. By clicking **Mark as Reviewed** you stamp the record with your name and the current date and time.

This visual indicator makes it easier for subsequent providers to see the last time someone reviewed this information.

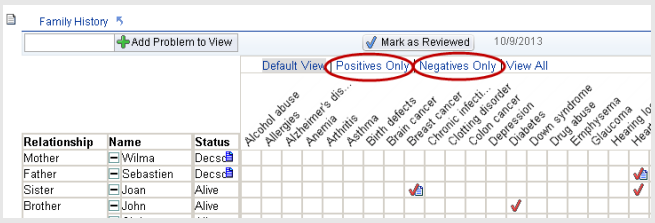
Impact of having Multiple Views in the Family History Visit Navigator Subsection

Care must be taken when viewing Family History information from the Visit Navigator subsection.

The **read-only mode** of the Family History subsection displays all of the noted positive and negative findings.



When opened in **edit mode**, the initial display of this section does not show the full history if a disease/problem was added which was not part of the Default View. When in edit mode, you must always use the Positives Only and Negatives Only views to view the complete family history.



REVIEW ALLERGIES

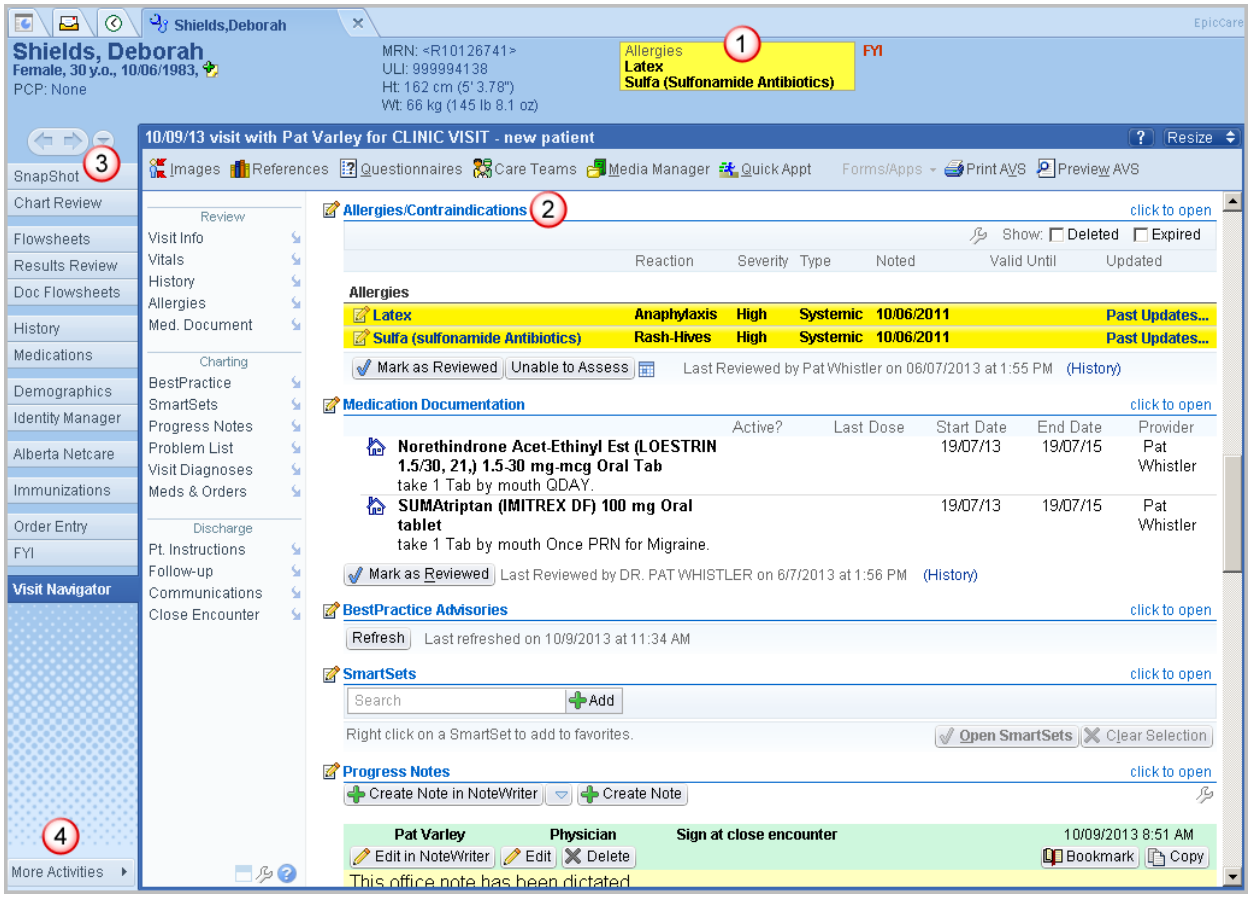
You can review the patient's allergies from one of the following locations:

① Patient Header

② Visit Navigator – Allergies section

③ SnapShot activity/report

④ Allergies/Contraindications activity (from the the More Activities menu).



Best Practice - Indicate Review of Current Findings

You'll see many places in the patient's chart where you can mark items as having been reviewed. By clicking **Mark as Reviewed** you stamp the record with your name and the current date and time.

This visual indicator makes it easier for subsequent providers to see the last time someone reviewed this information.

TIP 1: Allergies with a High severity display as bolded black text with a yellow background.

TIP 2: While you can view allergy information on the Patient Header you cannot mark them as being reviewed from this location.

Allergy Information in *e*CLINICIAN

The allergies listed in ***e*CLINICIAN - EMR** are from First Data Bank (FDB) Canada and therefore only relate to drug ingredients or drug classes.

To enter allergies not related to drugs, such as dust, hay fever or food allergies, use the **Other** category.

The allergies database in ***e*CLINICIAN** is updated quarterly with new allergens after approval by the Clinical Design Team.

Filtering of Allergy Alerts for Inactive Ingredients

Inactive drug ingredients (e.g. latex, peanut oil) are often used as fillers in medications. These inactive ingredients are not screened by FDB Canada.

The impact to ***e*CLINICIAN** is that if a patient has an allergy to an inactive ingredient, all subsequent medication orders would show an alert regardless of whether or not the medication contains the inactive ingredient.

In order to reduce the number of false positives and reduce alert fatigue the filtering of inactive ingredients has been **turned off** in ***e*CLINICIAN**.

UPDATE ALLERGIES

1. From the Visit Navigator table of contents, access the Allergies section. The Allergies/Contraindications section opens in edit mode.
2. In the **Add a new agent** field, use completion matching to search for the allergy.

Allergy Information in *e*CLINICIAN

The allergies listed in ***e*CLINICIAN - EMR** are from First Data Bank (FDB) Canada and therefore only relate to drug ingredients or drug classes.

To enter allergies not related to drugs, such as dust, hay fever or food allergies, use the **Other** category.

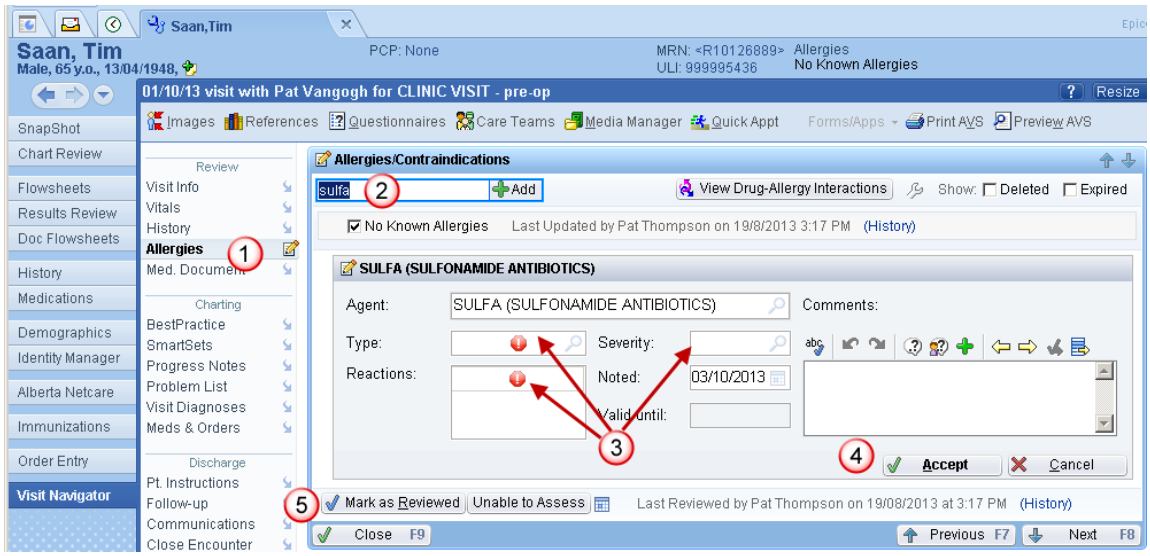
The allergies database in ***e*CLINICIAN** is updated quarterly with new allergens after approval by the Clinical Design Team.

3. Enter information about the allergy such as type, reactions, severity and date when noted.
4. When you are done, click **Accept**.
5. Click **Mark As Reviewed**. The last reviewed information updates to show your name, the date, and the time.

Best Practice - Indicate Review of Current Findings

You'll see many places in the patient's chart where you can mark items as having been reviewed. By clicking **Mark as Reviewed** you stamp the record with your name and the current date and time.

This visual indicator makes it easier for subsequent providers to see the last time someone reviewed this information.



DOCUMENT THAT A PATIENT HAS NO ALLERGIES

1. From the Visit Navigator table of contents, access the Allergies section. The Allergies/Contraindications section opens in edit mode.
2. Select the No Known Allergies checkbox.

When you select this checkbox, a comment displays with your name and the current date and time.

3. When you are done, click **Mark as Reviewed**. The last reviewed information updates to show your name, the date, and the time.

Best Practice - Indicate Review of Current Findings

You'll see many places in the patient's chart where you can mark items as having been reviewed. By clicking **Mark as Reviewed** you stamp the record with your name and the current date and time.

This visual indicator makes it easier for subsequent providers to see the last time someone reviewed this information.

Notice that when this activity/section is in read-only mode, No Known Allergies displays in a label below the check box and in the patient header.

Allergies/Contraindications
click to open
Show: Deleted Expired
No Known Allergies
Last Updated by Pat Varley on 10/9/2013 12:10 PM (History)
No Known Allergies
Mark as Reviewed
Unable to Assess
Last Reviewed by Pat Varley on 10/09/2013 at 12:10 PM (History)

TIP: When you add an allergy, the checkbox is automatically cleared and no longer displays.

REVIEW AND UPDATE THE CURRENT MEDICATION LIST

A review of a patient's current medications includes the review of:

- Medications prescribed from ***e*CLINICIAN**
- Medications not prescribed from ***e*CLINICIAN**
- Any clinically significant over-the-counter medications or herbal supplements

The latter two items are automatically flagged as a ***Patient Reported*** medication when entered in ***e*CLINICIAN**.

During a visit, clinical support staff may perform an initial review of the patient's medications using the Medication Documentation section of the Visit Navigator.

Clinical staff may prefer to do a more comprehensive review of the patient's current and past medications. The Medications & Orders section of the Visit Navigator can be used for this review as well as to update current medication details and to order and reorder the listed medications.

You can also see current medications on the Snapshot activity.

You can see a full list of current and historical medications from the Medication activity.

COMPARISON OF FUNCTIONALITY BETWEEN MEDICATION AREAS

The following table compares the medication features available between the following activities/navigator sections:

- Medication Documentation (Med. Document) navigator section
- Medications & Orders (Meds & Orders) navigator section
- Medications activity

	Med Document navigator section	Meds & Orders navigator section	Medications activity
Review Medications			
Document a patient reported med	✓	✓	
Mark a med as Taking	✓	✓	✓
View current medications	✓	✓	✓
View expired and discontinued meds		✓	✓
Mark existing med as long-term		✓	✓
Adjust Medications			
Reorder or change a med		✓	✓
Discontinue a current medication not ordered during today's encounter	✓	✓	✓
Discontinue a current med ordered during today's encounter	✓	✓	✓
Order Medications			
Order a new med		✓	
Reorder a previous med		✓	✓
Mark new med as long-term		✓	

REVIEW CURRENT MEDICATIONS USING THE MEDICATION DOCUMENTATION SECTION

1. From the Visit Navigator table of contents, access the Med. Document section.
2. You can choose different list views of the patient's medications by selecting the appropriate option in the ***Sort by:*** drop down menu.
3. For each medication that the patient is currently taking, click **Taking**. A red checkmark displays in the Taking column.

> **TIP 1**: To quickly mark a number of medications with the same status of Taking or Not Taking is the same for all of them, use the corresponding **Mark Unselected Taking** or **Mark Unselected Not Taking** button.

If no additions to the medication list are required, proceed to the next step.

If you need to add medications that were not prescribed from ***e*CLINICIAN** or any clinically significant over-the-counter medication or herbal supplement, proceed to the next topic**.**

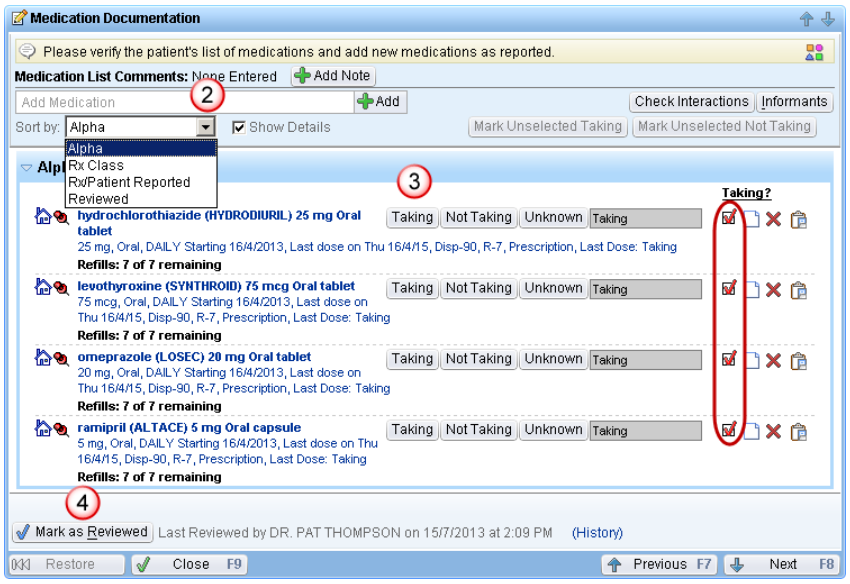
> **TIP 2**: The **Medication List Comments** hyperlink at the top of this section allows you to document a comment for the entire medication list. For example, "uses blister pack".

4. To indicate that you have reviewed the medications, click **Mark as Reviewed**. The last reviewed information updates to show your name, the date, and the time.

Best Practice - Indicate Review of Current Findings

You'll see many places in the patient's chart where you can mark items as having been reviewed. By clicking **Mark as Reviewed** you stamp the record with your name and the current date and time.

This visual indicator makes it easier for subsequent providers to see the last time someone reviewed this information.


Medication Documentation
Please verify the patient's list of medications and add new medications as reported.
Medication List Comments: None Entered
Add Note
Add Medication
Add
Check Interactions
Informants
Sort by: Alpha
Show Details
Mark Unselected Taking
Mark Unselected Not Taking
Alpha
Rx Class
Rx/Patient Reported
Reviewed
2
3
4
Taking?
hydrochlorothiazide (HYDRODIURIL) 25 mg Oral tablet
25 mg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription, Last Dose: Taking
Refills: 7 of 7 remaining
levothyroxine (SYNTHROID) 75 mcg Oral tablet
75 mcg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription, Last Dose: Taking
Refills: 7 of 7 remaining
omeprazole (LOSEC) 20 mg Oral tablet
20 mg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription, Last Dose: Taking
Refills: 7 of 7 remaining
ramipril (ALTACE) 5 mg Oral capsule
5 mg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription, Last Dose: Taking
Refills: 7 of 7 remaining
Taking
Not Taking
Unknown
Mark as Reviewed
Last Reviewed by DR. PAT THOMPSON on 15/7/2013 at 2:09 PM
(History)
Restore
Close F9
Previous F7
Next F8

UPDATE LIST OF CURRENT MEDICATIONS USING THE MEDICATION DOCUMENTATION SECTION

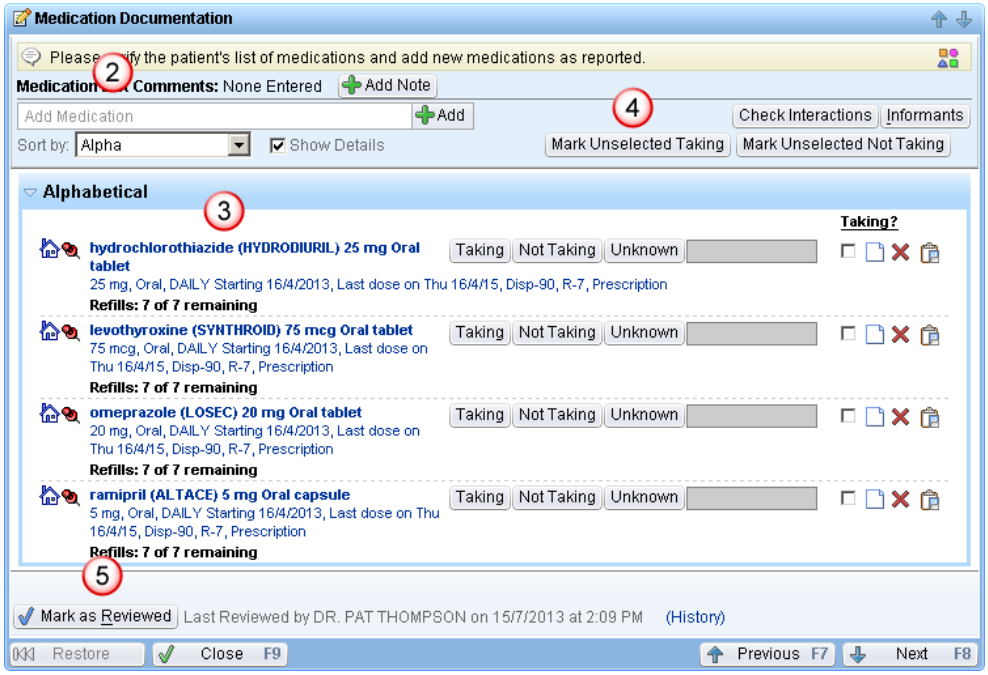
The Medication Documentation section of the Visit Navigator can be used to document medications that the patient is taking not prescribed from ***e*CLINICIAN,** as well as any clinically significant over-the-counter medications or herbal supplements.

1. From the Visit Navigator table of contents, access the Med. Document section.
2. In the **Add Medication** field, use completion matching to search for the appropriate medication. The Select a Medication window displays. Select the appropriate medication.
3. From the New Medications section that opens, enter the appropriate medication details. Click Accept.
4. Click on the **Mark Unselected Taking** button.
5. To indicate that you have reviewed the medications, click **Mark as Reviewed**. The last reviewed information updates to show your name, the date, and the time.

Best Practice - Indicate Review of Current Findings

You'll see many places in the patient's chart where you can mark items as having been reviewed. By clicking **Mark as Reviewed** you stamp the record with your name and the current date and time.

This visual indicator makes it easier for subsequent providers to see the last time someone reviewed this information.


Medication Documentation
Please verify the patient's list of medications and add new medications as reported.
2
Medication Comments: None Entered
Add Note
Add Medication
Add
4
Check Interactions
Informants
Sort by: Alpha
Show Details
Mark Unselected Taking
Mark Unselected Not Taking
Alphabetical
3
Taking?
hydrochlorothiazide (HYDRODIURIL) 25 mg Oral tablet
25 mg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription
Refills: 7 of 7 remaining
levothyroxine (SYNTHROID) 75 mcg Oral tablet
75 mcg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription
Refills: 7 of 7 remaining
omeprazole (LOSEC) 20 mg Oral tablet
20 mg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription
Refills: 7 of 7 remaining
ramipril (ALTACE) 5 mg Oral capsule
5 mg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription
Refills: 7 of 7 remaining
Taking
Not Taking
Unknown
5
Mark as Reviewed
Last Reviewed by DR. PAT THOMPSON on 15/7/2013 at 2:09 PM
(History)
Restore
Close F9
Previous F7
Next F8

Additional Notes about Medication Symbols

Patient Reported medication: Indicates that the patient is taking a medication that was not prescribed from ***e*CLINICIAN** or a clinically significant over-the-counter medication or herbal supplement.

Medication prescribed from ***e*CLINICIAN**.

Long term medication: Indicates a medication that the patient must take for a chronic condition. This medication might not be currently in the patient's system at the time of the visit. For example, an asthma medication. Long term medications remain on the current medication list even after their end dates pass.

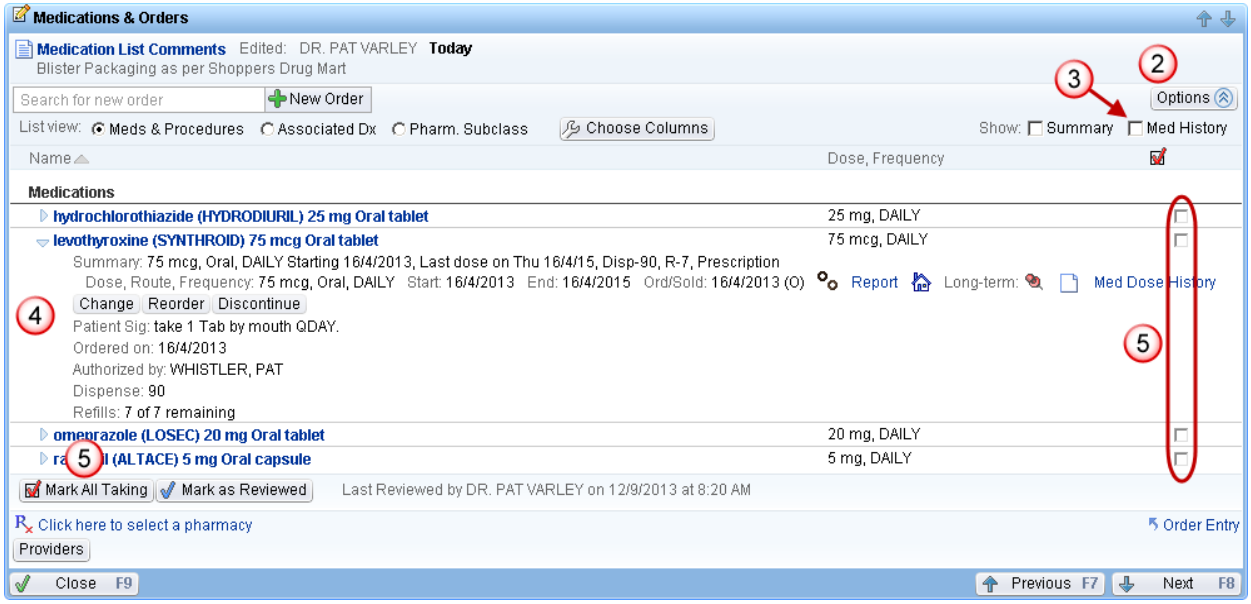
Taking medication: Indicates that the patient is taking the medication as prescribed.

To view a description of other icons, click the legend icon in the upper right-hand area of the section.

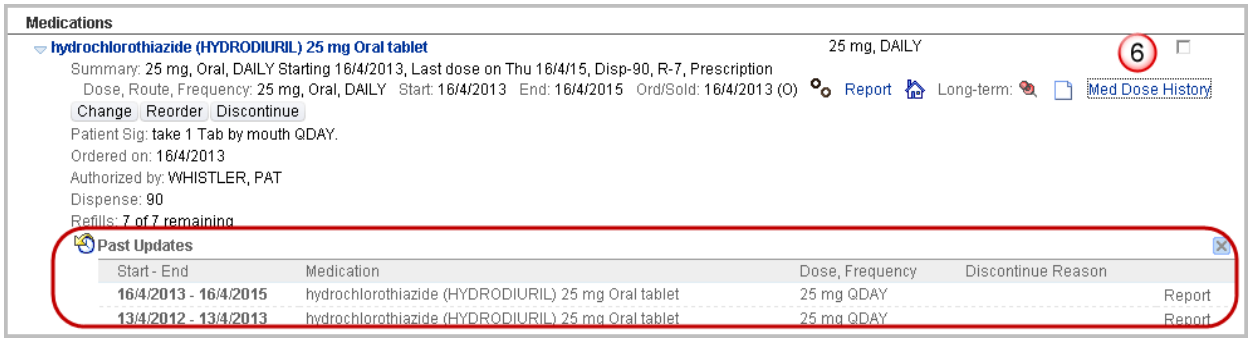
REVIEW AND UPDATE MEDICATION LIST FROM THE MEDICATIONS & ORDERS SECTION

1. From the Visit Navigator table of contents, access the Meds & Orders section.
2. To change the presentation of the medications listed, click **Options** and then the appropriate List view option.
3. To have the medication list also show discontinued medications, check the Med History checkbox.
4. To see the details for each medication, click the medication name hyperlink.
5. To mark each medication as being taken, click the respective Taking checkbox or click the **Mark All Taking** button.

TIP: If you check the Med History checkbox, the Taking checkbox is not available.



6. To see all the medication reorders, click the Med Dose History hyperlink. The Past Updates section displays showing the relevant details.



7. To indicate that you have reviewed the medications, click **Mark as Reviewed**. The last reviewed information updates to show your name, the date, and the time.

Best Practice - Indicate Review of Current Findings

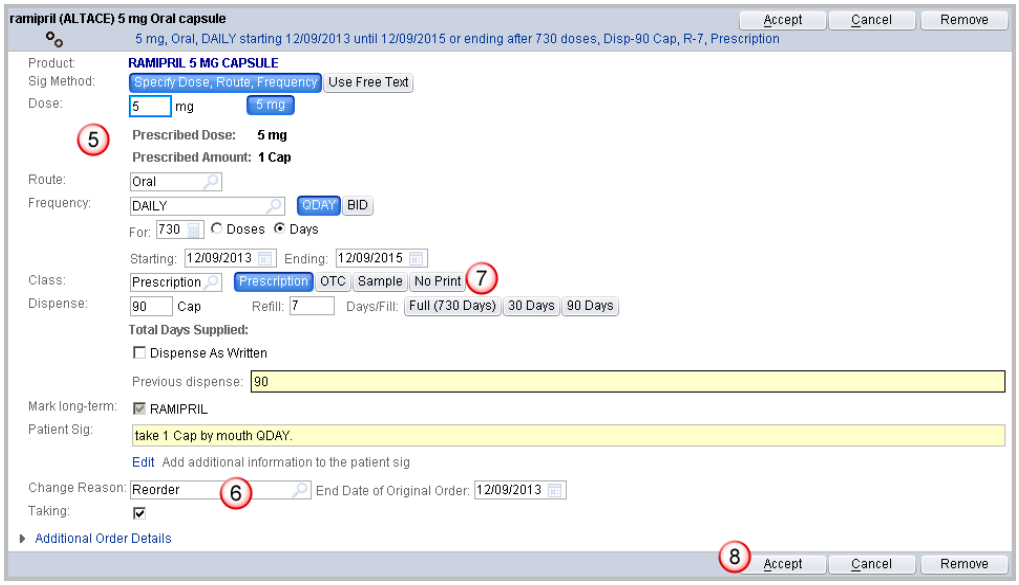
You'll see many places in the patient's chart where you can mark items as having been reviewed. By clicking **Mark as Reviewed** you stamp the record with your name and the current date and time.

This visual indicator makes it easier for subsequent providers to see the last time someone reviewed this information.

UPDATE MEDICATION DETAILS FOR A CURRENT OR EXPIRED MEDICATION

If, during a medication review, you discover that the details for a current medication need to be updated, or you need to extend the date for an expired medication, perform the following:

1. From the Visit Navigator table of contents, select Meds & Orders.
2. To have the medication list also show discontinued medications, in the Show area, select the Med History checkbox.
3. Click the medication name hyperlink.
4. Click **Change**. The Order Composer displays.
5. Update fields as required.
6. In the **Change Reason** field, use completion matching to select the appropriate reason for the medication change.
7. As a printed prescription is not required, click **No Print**.
8. Click **Accept**.



9. Sign or pend the order.

TIP: You can also make these updates using the Medications activity.

DOCUMENT ASSESSMENTS

You may already use a number of forms or flowsheets as patient assessment tools. In ***e*CLINICIAN-EMR**, these assessment tools are typically built as documentation or ***doc*** flowsheets. Doc flowsheets are ideal for tracking large amounts of patient data over time.

Remember that there is also a separate ***Flowsheets*** activity. The Flowsheets activity is different from the Doc Flowsheets activity in that it is a read-only tool and cannot be used to document patient findings.

USE DOCUMENTATION FLOWSHEETS

The Doc Flowsheets activity provides a place in an encounter where you assess the patient's status or response to assessment questions over time.

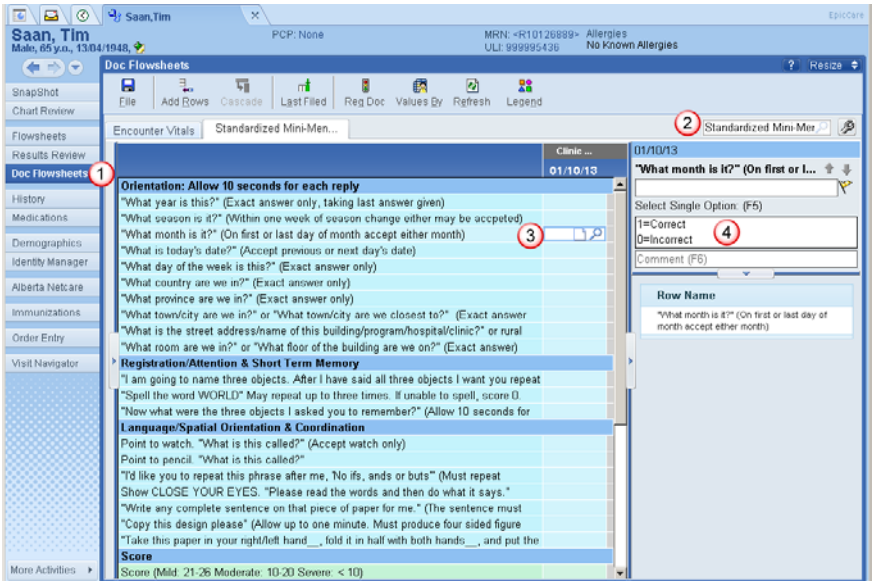
1. To access Documentation Flowsheets, select the Doc Flowsheets activity tab.

   TIP: You can also access the Doc Flowsheets activity from the **Go to Doc Flowsheets** hyperlink in the Vitals section of the Visit Navigator.

2. In the **Flowsheet name** field, type the name of the flowsheet or use the **Selection** tool (magnifying glass) to select from the list. The screen shot below uses the ***Standardized Mini-Mental State Exam*** (***SMMSE***) flowsheet as an example.

3. To record information/answer flowsheet questions manually, in the left-hand pane in the cells under column to the right of the question, enter the response.

4. To record information/answer flowsheet questions more quickly, in the right -hand pane, click the appropriate response. The questionnaire advances you to the next question.

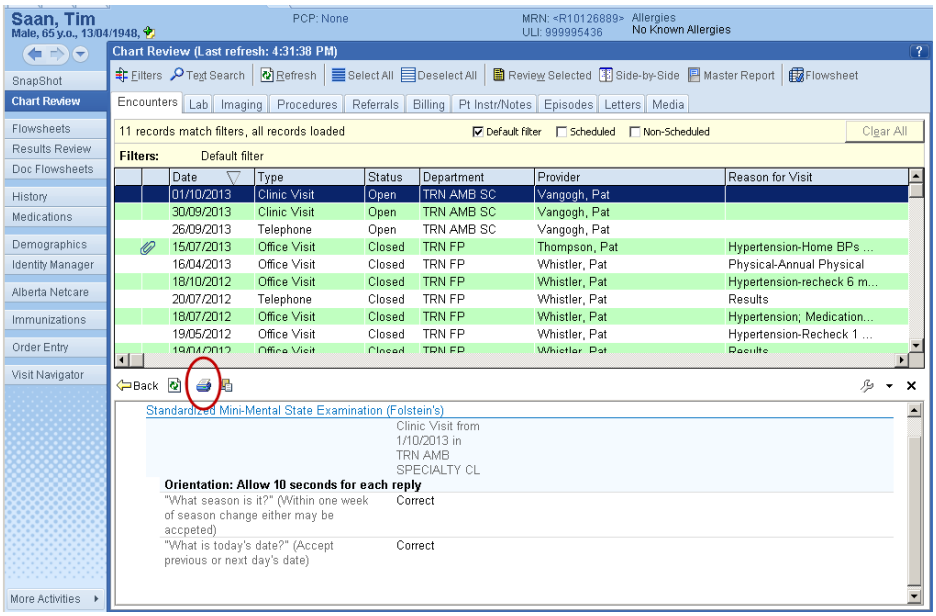

Saan, Tim
Doc Flowsheets
Standardized Mini-Men...
Orientation: Allow 10 seconds for each reply
"What year is this?" (Exact answer only, taking last answer given)
"What season is it?" (Within one week of season change either may be accpeted)
"What month is it?" (On first or last day of month accept either month)
"What is today's date?" (Accept previous or next day's date)
"What day of the week is this?" (Exact answer only)
"What country are we in?" (Exact answer only)
"What province are we in?" (Exact answer only)
"What town/city are we in?" or "What town/city are we closest to?" (Exact answer
"What is the street address/name of this building/program/hospital/clinic?" or rural
"What room are we in?" or "What floor of the building are we on?" (Exact answer)
Registration/Attention & Short Term Memory
"I am going to name three objects. After I have said all three objects I want you repeat
"Spell the word WORLD" May repeat up to three times. If unable to spell, score 0.
"Now what were the three objects I asked you to remember?" (Allow 10 seconds for
Language/Spatial Orientation & Coordination
Point to watch. "What is this called?" (Accept watch only)
Point to pencil. "What is this called?"
"I'd like you to repeat this phrase after me, 'No ifs, ands or buts'" (Must repeat
Show CLOSE YOUR EYES. "Please read the words and then do what it says."
"Write any complete sentence on that piece of paper for me." (The sentence must
"Copy this design please" (Allow up to one minute. Must produce four sided figure
"Take this paper in your right/left hand__, fold it in half with both hands__, and put the
Score
Score (Mild: 21-26 Moderate: 10-20 Severe: < 10)
Select Single Option: (F5)
1=Correct
0=Incorrect
Comment (F6)
Row Name
1
2
3
4

More on Doc Flowsheets

- Some doc flowsheets are designed to do calculations. In these types of flowsheets, the data you enter is used to calculate a total.
- You can add a comment to any response by clicking on the paper icon to the left of the **Selection** tool.
- You can flag an answer as significant by **right-clicking** it. The cell turns yellow.
- If an entered response has been changed, a red flag indicator appears in the upper right of the cell. By clicking on the cell, you can see who changed the answer and what day and time.
- When working with multiple flowsheets you can move between the flowsheets by clicking the tab for the appropriate flowsheet on the toolbar.

PRINT A DOCUMENTATION FLOWSHEET

1. Access the Chart Review activity.
2. From the Encounters tab, click the row or the corresponding encounter. The Encounter report displays.
3. Scroll through the report to find the Additional Encounter Details heading.
4. Click the Flowsheets, Questionnaires, Images, and Forms hyperlink.
5. Under All Flowsheet Templates, click the name of your flowsheet.
6. From the toolbar, click the printer icon.



DOCUMENT CARE TEAMS

The Care Teams functionality provides you with a single list of providers and clinicians responsible for the patient's long term care.

Two types of patient care teams are supported:

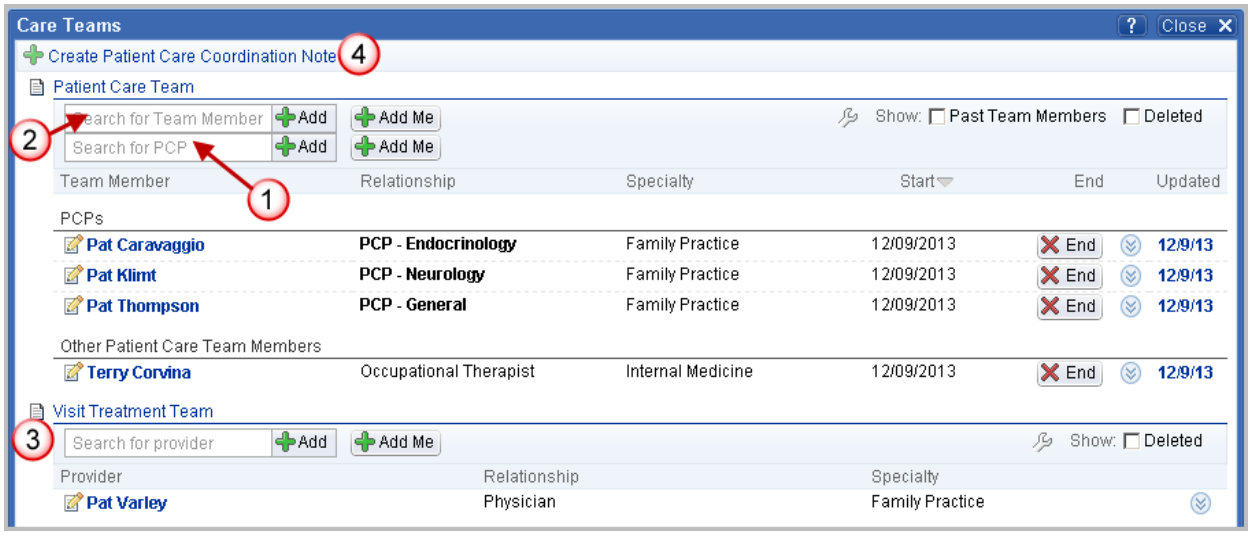
- The ***Patient Care Team*** identifies everyone involved with the long term care of the patient. The patient care team is made up of PCPs (Primary Care Providers) and non-PCP members. PCP members include the patient's family practice physician as well as the specialists who also treat the patient (i.e., the patient's cardiologist, neurologist, etc.). The non-PCP members include roles such as the patient's physical therapist, social worker or outside agencies who are also involved in the patient's care.
- The ***Visit Treatment Team*** identifies all of the clinicians working with a patient during a scheduled encounter.

The Care Teams activity provides a single access point for managing the patient's various care providers.

From the Care Teams activity you can perform the following:

① View and edit the patient's PCP (Primary Care Provider)
② View and edit other members of the Patient Care team
③ View and edit the Visit Treatment team, and
④ Add and edit Patient Care Coordination notes:

You can use the Patient Care Coordination note to record information about treatment the patient is receiving or about general care information. The note is viewable by all providers but only one Patient Care Coordination note can be created per patient. Previous versions of this note can be viewed by clicking on Past Versions when in edit mode. For users with the appropriate permissions, this functionality is also available from the patient's problem list.



Care Teams & Notes Report

The **Care Teams & Notes** report displays information about the patient's care team members, as well as your last outpatient progress note and the current Patient Care Coordination note (if there is one).

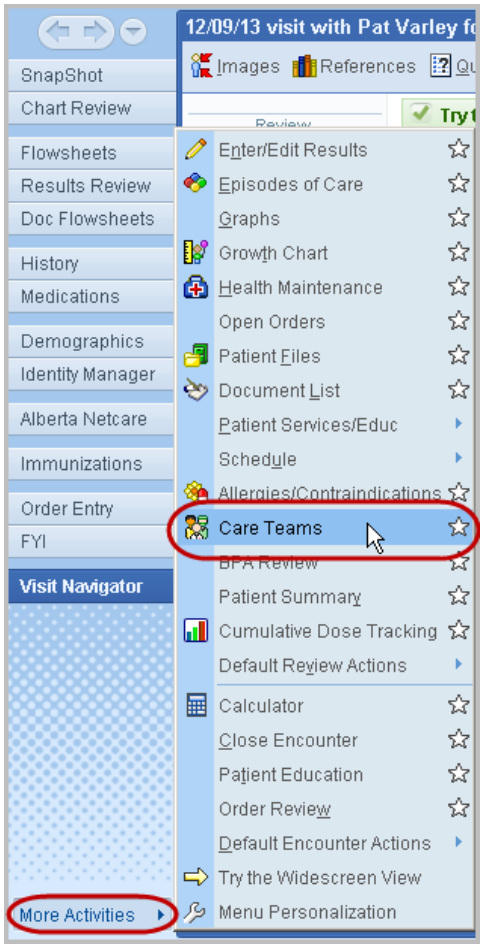
The report can be accessed from the following locations:

- The report pane on the Schedule activity. We recommend adding this report next to Snapshot report.
- The Snapshot activity in the patient's chart.

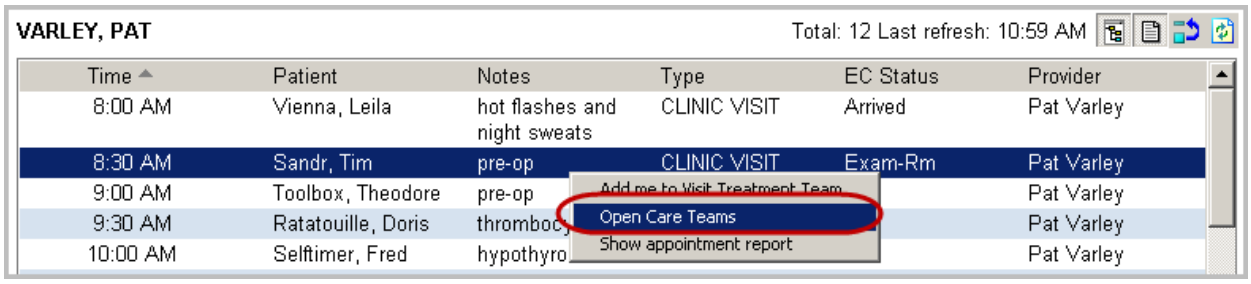
For information on how to add this report, Refer to the **Personalize *e*CLINICIAN** section.

ACCESS THE CARE TEAMS ACTIVITY

Within the patient's chart, the Care Teams activity is accessed from the More Activities menu in the Activity tab list.



You can also access the Care Teams activity from the Schedule activity. Select the patient's appointment and then **right-click** and select Open Care Teams.



ASSIGN A PCP MEMBER TO THE PATIENT CARE TEAM

Note: These steps are typically done by front desk staff. Setting up default PCPs for a patient can save time during the scheduling workflows such as booking appointments and checking in the patient for their appointment.

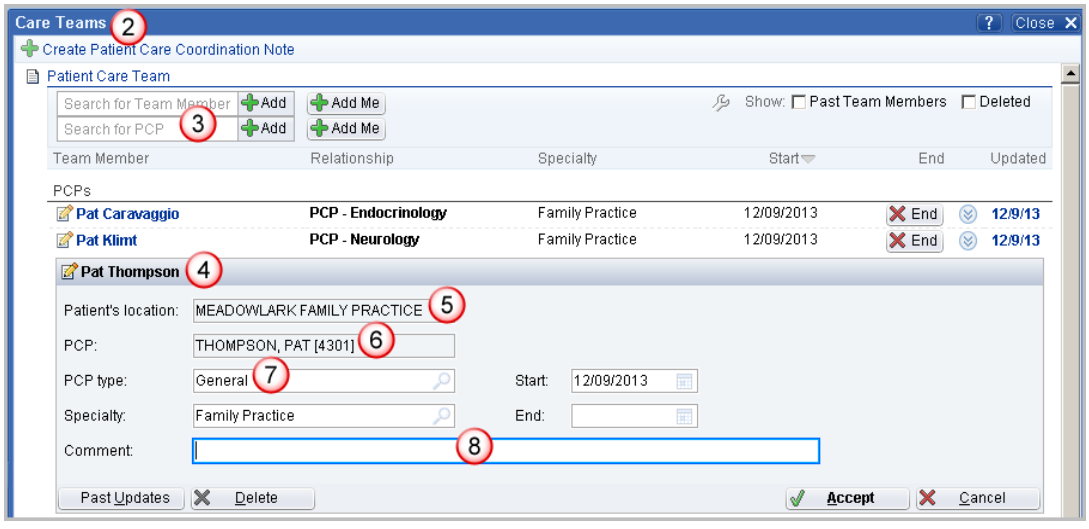
A patient can have one or more PCPs defined as long as each PCP is of a different type or specialty.

The PCP type of ***General*** is used to identify the patient's Family Practice physician. Only the PCP-General displays in the header on the patient's workspace.

1. Access the Care Teams activity.

   TIP 1: To access the Care Teams activity, refer to the previous topic.

2. The Care Teams activity displays.



3. To add a PCP to the patient's record, in the Patient Care Team area, click **Add** (to the right of the **Search for PCP** field).

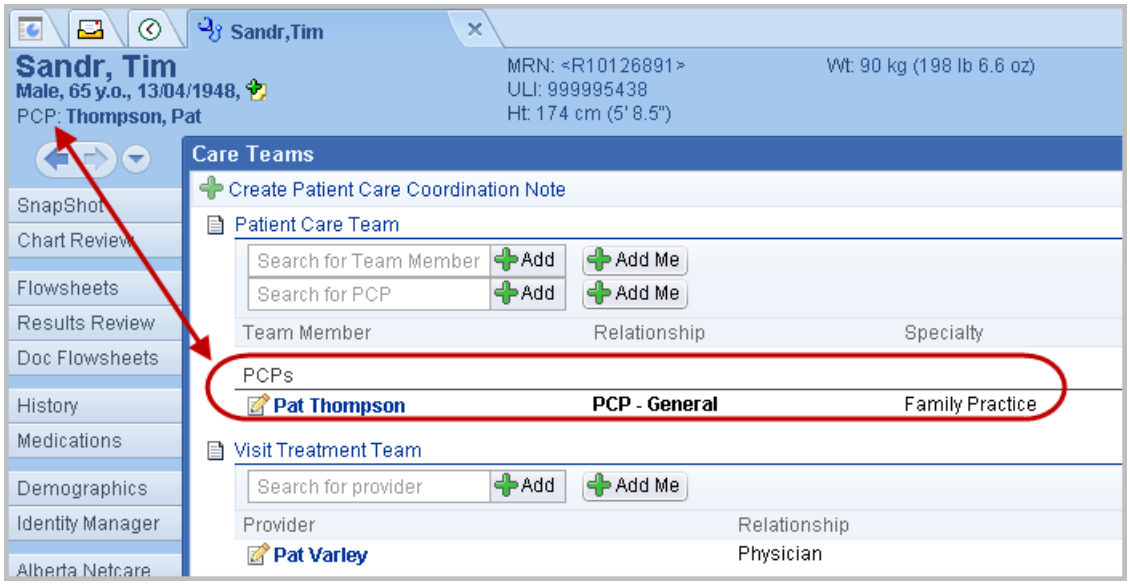
4. The New PCP details area displays.

5. In the **Patient's location** field, use completion matching to select the name of the department.
6. In the **PCP** field, use completion matching to select the name of a primary care provider.
7. In the **PCP type** field, use completion matching to select the type of provider.

   TIP 2: Remember that each PCP type can be used only once and that the **PCP-General** type is used to represent the patient's Family Practice physician.

8. In the **Specialty** field, use completion matching to select the PCP's specialty. If appropriate, type a comment.
9. When you are done, click **Accept**. The names of the PCPs display in the PCPs area.

   In the screenshot below, a PCP-General was added to the Care Team. This information now displays in the Patient Header.



   TIP 3: You can use the **End** button to stamp an end date on the relationship with the PCP.

   TIP 4: To update details on the PCP member, click the member's name.

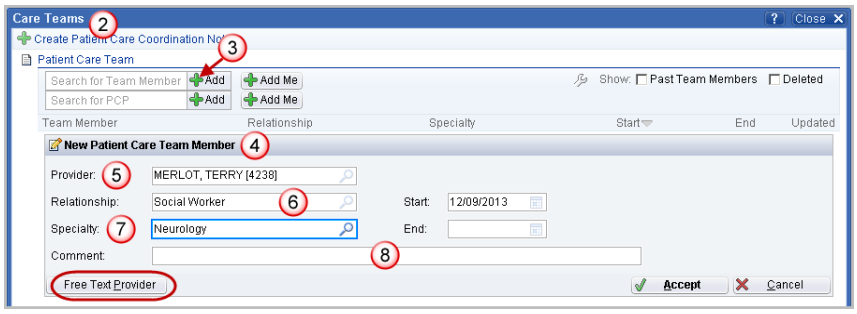
10. To close the Care Teams activity, click **Close**.

ASSIGN A NON-PCP MEMBER TO THE PATIENT CARE TEAM

Non-PCP members on the patient's care team represent roles such as the patient's physical therapist, dieticians, social workers or an outside agency who might be involved with the patient's care.

As only one PCP can be defined per specialty, additional specialists in the same specialty need to be identified as non-PCP members.

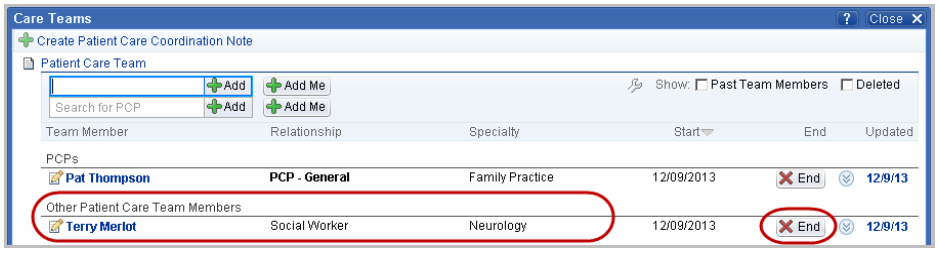
1. Access the Care teams activity.
2. The Care Teams activity displays.



3. To add a non-PCP member, in the Patient Care team area, to the right of the **Search for Team Member** field, click **Add**.
4. The New Patient Care Team Member details area displays.
5. In the **Provider** field, use completion matching to select the name of the provider.

   TIP 2: To add a provider/agency that is not in the list, use the **Free Text Provider** button to populate details on this non-PCP care team member.

6. In the **Relationship** field, use completion matching to select the member's role with the patient.
7. If required, in the **Specialty** field use completion matching to select the member's specialty.
8. If appropriate, type a comment.
9. When you are done, click **Accept**. The name of the member displays in the Other Patient Care Team Members area.



TIP 3: You can use the **End** button to stamp an end date on the relationship with the PCP.

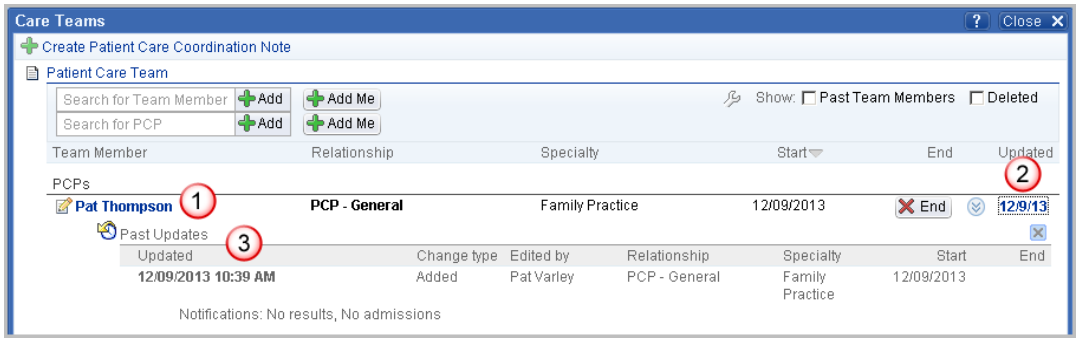
TIP 4: To update details on the non-PCP member, click the member's name.

10. To close the Care Teams activity, click **Close**.

VIEW PAST UPDATES TO PATIENT CARE TEAM MEMBERS

You can view past updates (audits) to the PCP and non-PCP members of the Patient Care team.

1. From the Care Teams activity, locate the patient care member.



2. Click the date hyperlink located below the Updated column.
3. The Past Updates detail area displays for the indicated patient care team member.

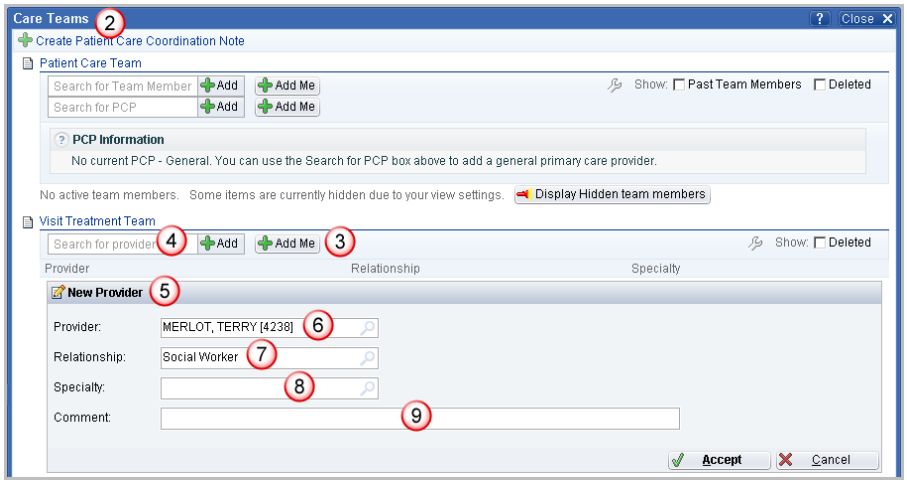
ASSIGN A MEMBER TO THE VISIT TREATMENT TEAM

The Visit Treatment team can be used to identify all of the clinicians working with a patient during a scheduled encounter. For example, you may want to include the names of the resident who saw the patient during the visit.

1. Access the Care teams activity.
2. The Care Teams activity displays.
3. To add yourself to the visit treatment team, in the Visit Treatment Team area, click **Add Me.**

   TIP 2: You can also add yourself to the Visit Treatment team using the Schedule activity. Select the patient's appointment and then **right-click** and select **Add me to the Visit Treatment Team**.

4. To add someone else to the Visit Treatment team, in the Visit Treatment Team area, click **Add.**
5. The New Provider details area displays.
6. In the **Provider** field, verify the information or use completion matching to select the name of the visit team member.
7. In the **Relationship** field, use completion matching to select the member's role with the patient.
8. If required, in the **Specialty** field use completion matching to select the member's specialty.
9. If appropriate, type a comment.



10. When you are done, click **Accept**. The name of the member displays in the ***Visit Treatment Team*** area.

11. To close the Care Teams activity, click **Close**.

WRITE NOTES

e*CLINICIAN - EMR** offers many tools to help you efficiently document your progress or procedure notes. The intention is not necessarily to change ***what you document in your progress note, but the ***way*** that the information is entered in the chart. It's important to note some of these tools take some time and practice to master. In order to use charting tools effectively, it's necessary to spend some time learning to use them and customizing them to fit your needs.

This chapter helps you choose the most effective and efficient option for each situation and describes how to use these tools to compose your note.

The following main topics are covered in this chapter:

- Review Options for Creating Progress Notes
- Write Progress Notes
- Review Additional Progress Note Features
- Write Procedure Notes

REVIEW OPTIONS FOR CREATING PROGRESS NOTES

You can create your progress note using any of the following ways:

- Type it
- Use SmartTools
- Use the NoteWriter forms
- Use partial dictation
- Use voice recognition software such as Dragon

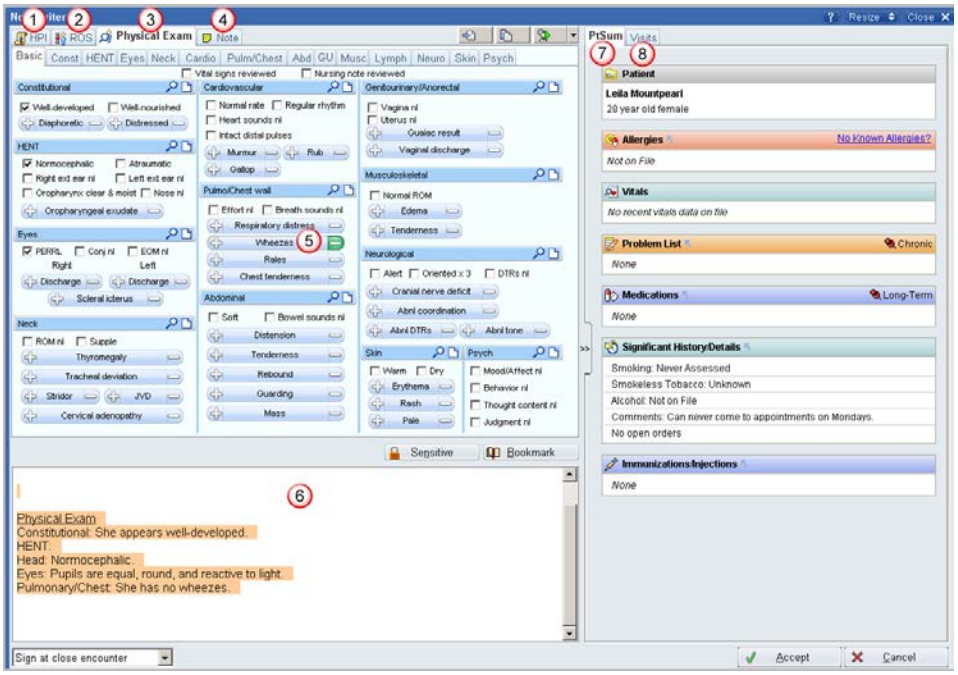
In many cases, the most efficient way to write a note is to use a combination of these methods.

One of the most common approaches involves using the NoteWriter tool to record the review of systems (ROS), physical exam (PE) along with SmartTools. You can use partial dictation or voice recognition software to record the history of present illness (HPI), assessment and plan for more complex patients.

NOTEWRITER

NoteWriter is a point-and-click documentation tool. It is effective for capturing a review of systems or a physical exam. As you make selections in NoteWriter, the system generates note text automatically, based on those selections.

There are several distinct areas of the NoteWriter tool.



① **HISTORY OF PRESENT ILLNESS (HPI) TAB**:

② **REVIEW OF SYSTEMS (ROS) FORM**: Contains a series of tri-state buttons and checkboxes, organized by system type.

③ **PHYSICAL EXAM FORM**: Contains a series of tabs representing the various systems. Within those tabs, there are tri-state buttons, checkboxes, and areas to document graphical information. The default tab is the Basic tab and contains a subset of selections found under the respective tab.

④ **NOTE FORM**: Allows you to view the note that the system generates based on your selections in the HPI, ROS, and, PE forms.

⑤ **TRI-STATE BUTTON CONTROLS**: By default, the buttons are in a neutral state, but can also have positive or negative orientations.

Work with Tri-State Control Buttons

To mark an item positive:

- Click the **plus sign** on the button, or
- Left-click the item name, or
- Press the **+** (Plus) key on your keyboard.

To mark an item as negative:

- Click the **minus sign** on the button, or
- Right-click the item name, or
- Press the **–** (Minus) key on your keyboard.

⑥ **TAB NOTE BOX**: Displays the note text the system generates based on your selections only for the form you are currently using.

⑦ **SNAPSHOT TAB**: Displays by default to make patient information accessible without having to leave the NoteWriter activity. To close the Snapshot pane, to the right of the NoteWriter form, in the middle of the screen, click the double chevrons (>>). To reopen the pane, on the far right, click the double chevrons again.

⑧**VISITS TAB:** Allows you to view and access previous encounters. The Chart Review hyperlink takes you to that activity. Relevant Encounters (Last 2 years) will display with a date hyperlink. Click the hyperlink to view the encounter details in a Generic Report format.

> **TIP**: You can make documentation even easier with NoteWriter SmartBlock macros that automate your selections. To learn more about this, refer to the **Personalize *e*CLINICIAN** section.

There are many benefits to using NoteWriter:

- When you use NoteWriter, the data you enter is captured discretely, meaning that you can report on it later.
- Using the NoteWriter is also effective for creating drawings and annotating images.
- In addition to the review of systems and the physical exam, you can use NoteWriter to document a patient's history of present illness. Depending on the patient's complaints, you might find that other documentation tools are better suited for capturing HPI, especially when you're dealing with a complex patient or a patient presenting for acute care.
- You can easily fill out the point-and-click forms while you're in the room with the patient, allowing you to maintain your focus on patient care without having to concentrate on typing.

SMARTTOOLS

SmartTools are discussed in detail in the topic ***e*CLINICIAN** Fundamentals. They are effective for documenting a visit that conforms to a specific template. For example, well-child visits, annual physicals or pre-op exams usually follow a set course. For these visits, you can pull in a SmartText or SmartPhrase to complete most of the documentation, and then fill in the blanks where specific patient information is needed.

For patients with chronic problems, you can compose an initial note using SmartTools and copy that note forward each time the patient comes in for a follow-up visit. Any refreshable SmartLinks in the note are automatically updated to reflect information from the current visit, so you only need to adjust other note details, if required.

VOICE RECOGNITION

For your initial visit with a complex patient or an acute care visit, voice recognition is a good alternative to typing. You can use voice recognition to invoke SmartTools or other commands in Hyperspace. The use of voice recognition in ***e*CLINICIAN - EMR** requires installation of a third-party product, such as Dragon NaturallySpeaking. Remember that if you rely solely on voice recognition, you won't be capturing discrete data in your note.

PARTIAL DICTATION

Partial Dictation is the term used to describe the process whereby the progress note is generated using a documentation method, such as NoteWriter, in conjunction with dictation. The workflow involves inserting a tag in the progress note where the transcription of the dictation will go. The tag uniquely identifies the dictation. The physician dictates the note into a third party device and references the tag number.

The dictation is routed to the In Basket, ***e*CLINICIAN-EMR**'s electronic messaging system, to an administrative support pool. The transcription is then routed back to the dictating physician's In Basket for approval.

Avoid Duplication in your Progress Notes

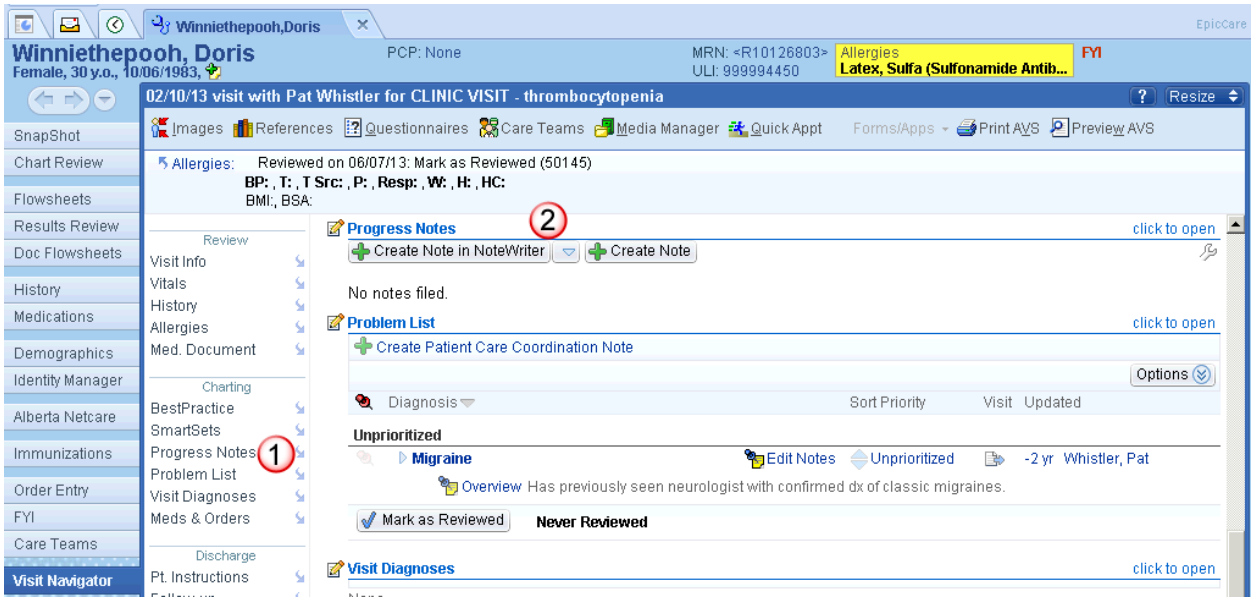
The Encounter Report (Chart Review activity) is the summary report for the complete visit. Because the encounter summary report already includes such things as vitals, diagnoses, and orders, consider that you may not need to duplicate this information in your note.

WRITE PROGRESS NOTES

During the visit, use the Progress Notes section of the Visit Navigator to create your notes.

BEGIN CREATION OF YOUR NOTE

1. From the Visit Navigator table of contents, access the Progress Notes section. The Progress notes section displays with three button options for creating notes:
   - **Create Note in NoteWriter** is used primarily by physicians, senior residents, and nurse practitioners to document findings.
2. The Down Arrow allows users to choose between NoteWriter forms:
   - STANDARD NOTE: Opens with the standard NoteWriter forms.
   - PROCEDURE NOTE: Opens a procedure based NoteWriter template.
   - BLANK NOTE: Opens a blank NoteWriter form.
   - **Create Note** opens a blank note and contains SmartText forms. **Create Note** is used primarily by Allied Health professionals to document findings.



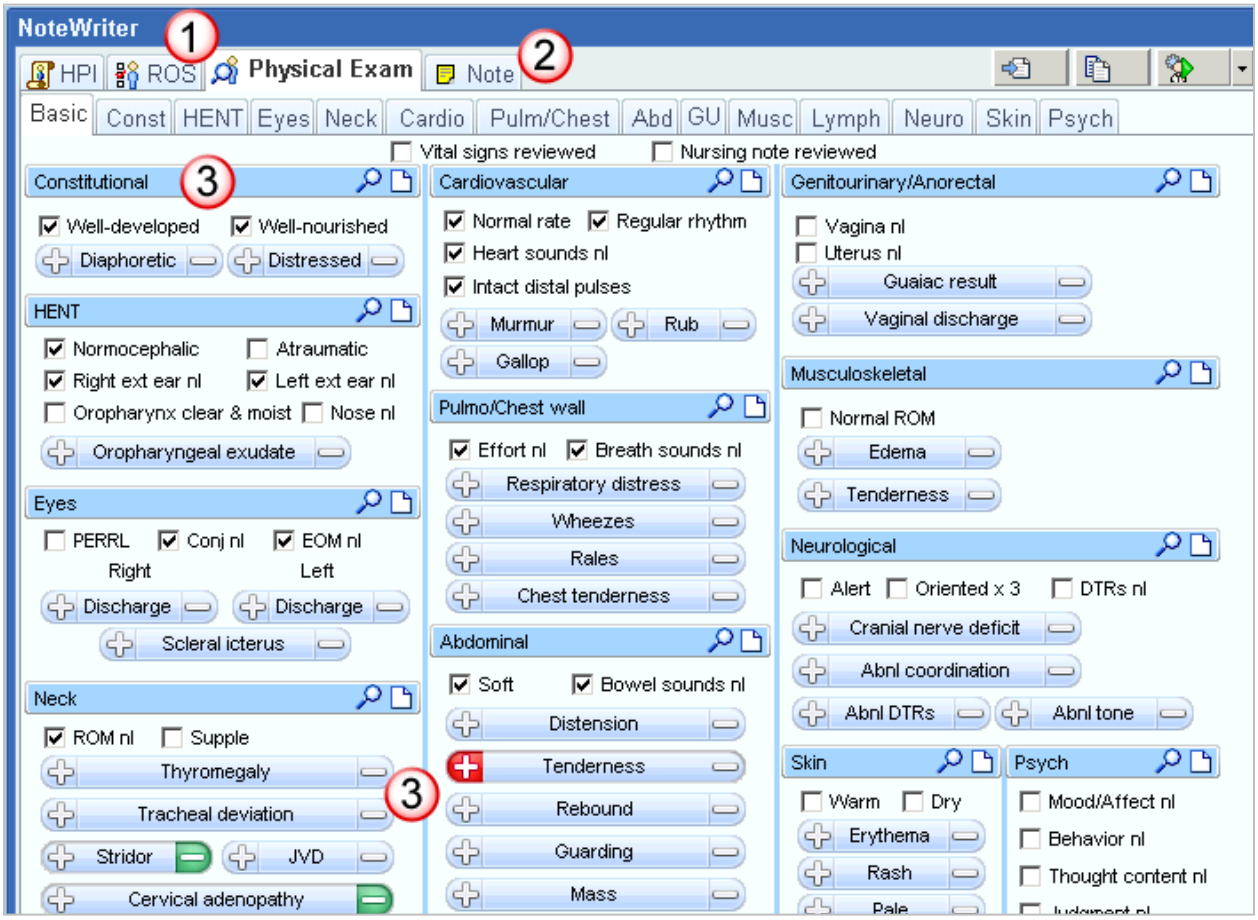
3. From the options listed above, you will select the appropriate option. To continue working through this section, click **Create Note in Notewriter**.

TIP 1: If NoteWriter opens in full-screen mode, you can click **Resize** to fit it within the workspace. The system remembers how you viewed the NoteWriter the last time you accessed it and opens it in that mode again.

CREATE NOTE USING NOTEWRITER

The NoteWriter activity is divided into four forms:

1. The HPI, ROS and Physical Exam forms are designed to allow you to generate your note as discrete data. By simply clicking your mouse and adding comments and diagrams, the NoteWriter creates the text of your note.
2. The Note form is where your note takes shape whether you are using the other NoteWriter forms, partial dictation, SmartTools or directly typing your note.
3. To complete the documentation on the HPI, ROS and (PE) Physical Exam forms, click the appropriate check boxes or use the tri-state control buttons.



Work with Tri-State Control Buttons

To mark an item positive using tri-state control button:

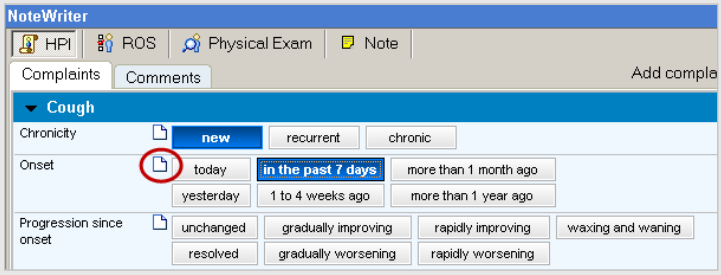
- Click the **plus sign** on the button, or
- Left-click the item name, or
- Press the **+** (Plus) key on your keyboard.

To mark an item as negative using a tri-state control button:

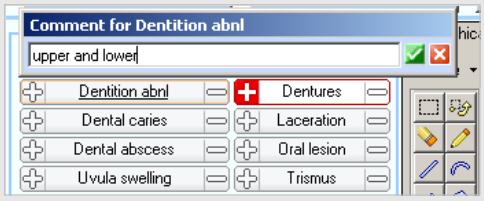
- Click the **minus sign** on the button, or
- Right-click the item name, or
- Press the **–** (Minus) key on your keyboard.

Add Comments to NoteWriter Forms

If you don't see an option on the form, you can add a comment by clicking the paper icon in the appropriate section of the form.



To add a comment for an item displayed as a tri-state control, hover your mouse over the button and just start typing. You can also double-click the center of the tri-state control. To accept your comment, click the green check mark on the Comment window or press Enter. The tri-state control item then displays with the item name underlined.



In the progress note, the comment will appear in parentheses.

TIP 2: From the Physical Exam tab, click one of the icons to access the detailed tab for that system.

TIP 3: To add a drawing to an image that appears, select one of the drawing tools, and then click and drag your mouse over the area of the image where you want to use the tool. For example, you might use one of the stencils available to you to indicate the location of a particular type of incision.

TIP 4: To add text (an annotation) to your image, select #, click the place on the image where you want to add the annotation, type your annotation text, and then click Accept.

4. Return to the Note form and review your note.

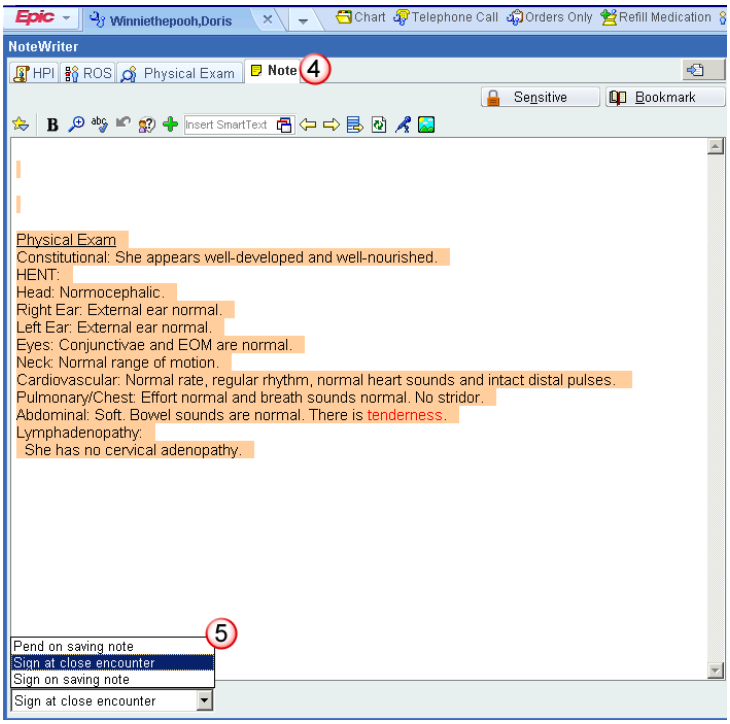
The orange highlighting you see on the Note form indicates a SmartBlock. As you make selections on the HPI, ROS and Physical Exam tabs, the respective SmartBlock populates and contains the text that represents your selections. The highlighted text cannot be edited directly. You must return to the appropriate form in NoteWriter and alter your original selection in order to change the text displayed.

5. By default Progress Notes are signed when the encounter is closed. To make further modifications to a signed note, you would have to create an addendum to the note. If you want to save the note and return to it after the patient visit, change the option to Pend on saving note. Another option is to Sign on saving note. You cannot close a scheduled encounter without a signed progress note. Keep this in mind when deciding how to sign the note.

Note the signing options available:

- The default is: Sign at close encounter
- Pend on saving note will prevent the encounter from being closed until your note is signed. You will also receive an In Basket reminder message that you have a pended note.
- Sign on saving note: Lets others know this note is complete. In clinics where multiple providers are documenting in the patient's chart, this can be helpful.

Notes that are pended or signed, may still be edited or addended afterwards.



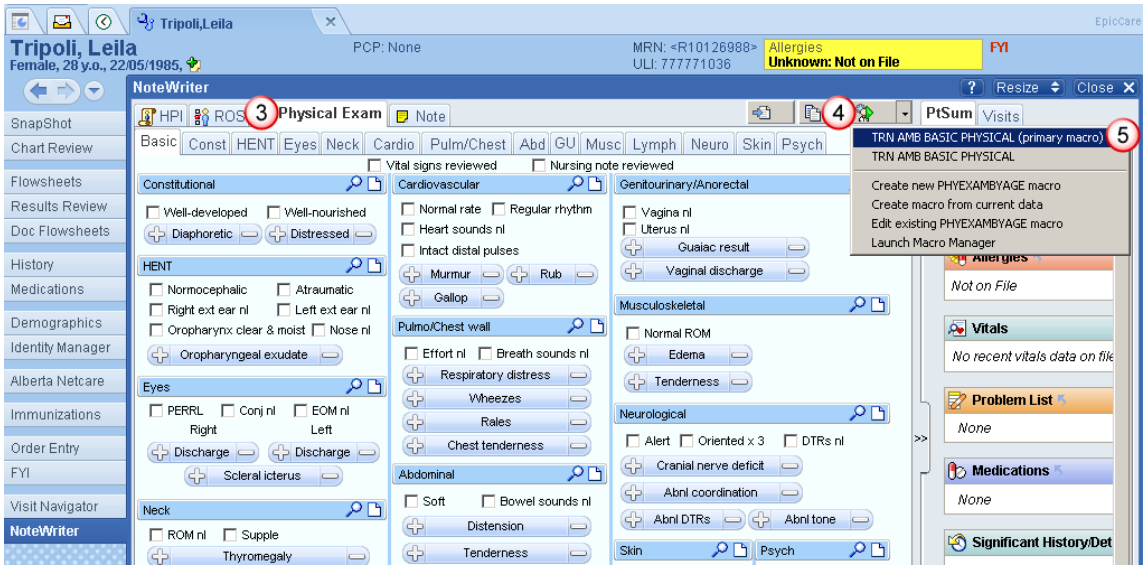
TIP 5: You can also type free text and use SmartTools such as SmartPhrases and SmartLinks in conjunction with NoteWriter. Place your cursor under and outside of the appropriate SmartBlock and begin typing or accessing SmartTools. To learn more about documenting with SmartTools, refer to the **Use SmartTools** section.

CREATE NOTE USING SMARTBLOCK MACROS

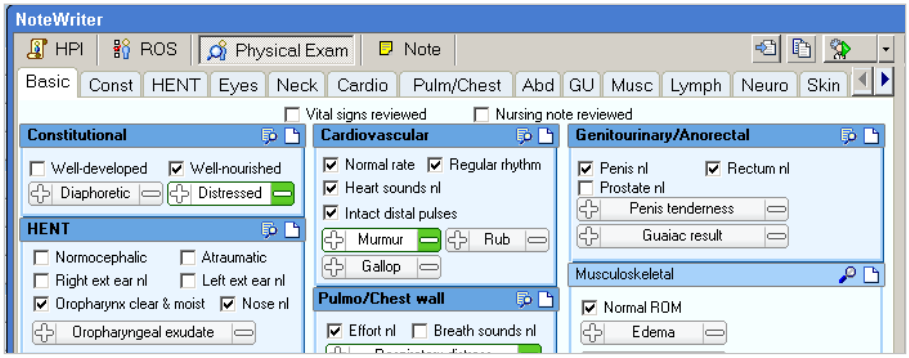
The use of SmartBlock macros is one way that you can drastically reduce the time it takes to document progress notes for routine exams. SmartBlock macros are only accessible from the ROS and the Physical Exam forms in NoteWriter.

For example, using a SmartBlock macro that was created for a pre-op physical quickly populates the most common findings. You can then update the selections for any abnormal findings.

1. From the Visit Navigator table of contents, access the Progress Notes section.
2. Click **Create Note in NoteWriter**. The NoteWriter activity opens, displaying a blank Note form.
3. Select either the ROS form or Physical Exam form.
4. On the far right of the toolbar, click the black down arrow. The Macro menu displays.
5. Select the appropriate macro to load.



6. To confirm the loading of the macro, click **OK**. The macro loads into NoteWriter, automatically generating selections on the form.



7. Review and edit the defaulted selections. Add new selections as required.
8. To review the completed note text, from the NoteWriter toolbar, click **Note**.

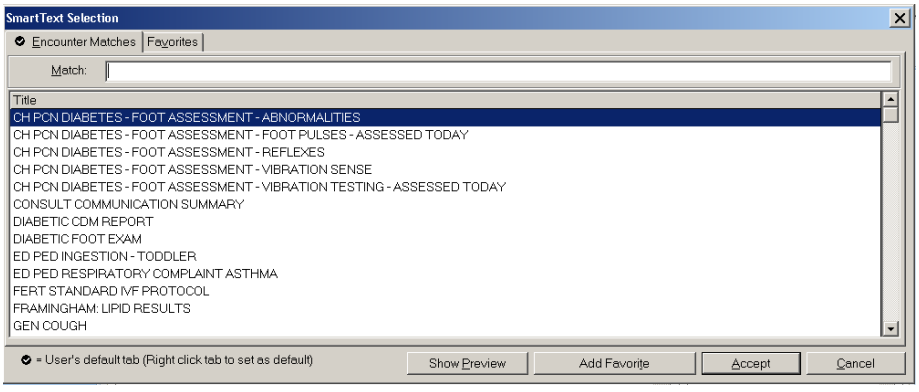
   TIP: You can also type free text and use SmartTools such as SmartPhrases and SmartLinks in conjunction with SmartBlock macros. Place your cursor under and outside of the appropriate SmartBlock and begin typing or accessing SmartTools. To learn more about documenting with SmartTools, refer to the **Use SmartTools** section.

9. Once you are finished with your note, confirm your note signing option, and click **Accept** to close NoteWriter.

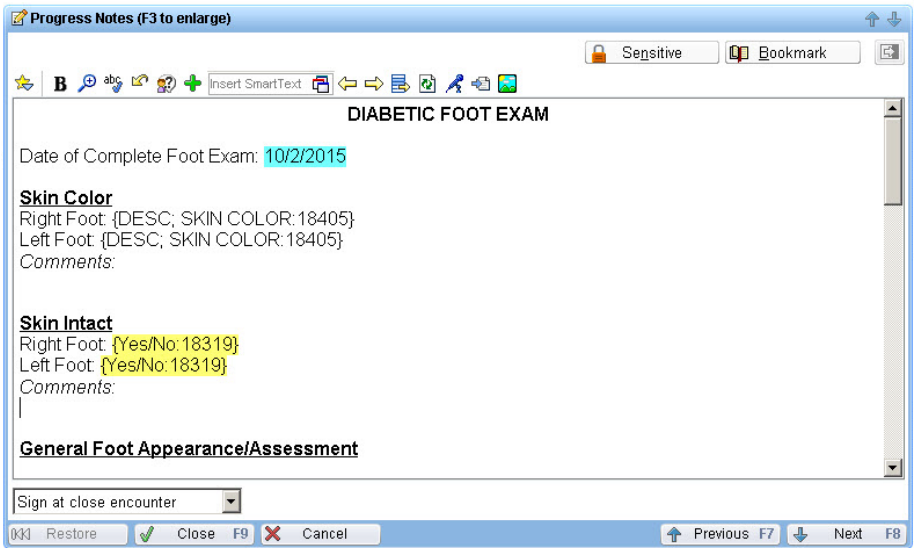
CREATE NOTE USING SMARTTEXT

Most of the note templates developed for use by Allied Health professionals will be developed as SmartText.

1. From the Visit Navigator table of contents, access the Progress Notes section.
2. Click **Create Note**. A blank SmartTool-enabled Progress Note window displays.
3. From the SmartTool toolbar, click (**Open Selection Entry**). You can also type the name of the SmartText directly into the Insert Smart Text field.
4. From the SmartText Selection window, select the appropriate note template.


SmartText Selection
Encounter Matches
Favorites
Match:
Title
CH PCN DIABETES - FOOT ASSESSMENT - ABNORMALITIES
CH PCN DIABETES - FOOT ASSESSMENT - FOOT PULSES - ASSESSED TODAY
CH PCN DIABETES - FOOT ASSESSMENT - REFLEXES
CH PCN DIABETES - FOOT ASSESSMENT - VIBRATION SENSE
CH PCN DIABETES - FOOT ASSESSMENT - VIBRATION TESTING - ASSESSED TODAY
CONSULT COMMUNICATION SUMMARY
DIABETIC CDM REPORT
DIABETIC FOOT EXAM
ED PED INGESTION - TODDLER
ED PED RESPIRATORY COMPLAINT ASTHMA
FERT STANDARD IVF PROTOCOL
FRAMINGHAM: LIPID RESULTS
GEN COUGH
= User's default tab (Right click tab to set as default)
Show Preview
Add Favorite
Accept
Cancel

5. Click **Accept**. The SmartText is inserted into the documentation box. The SmartText may include SmartLists and SmartLinks.



6. Complete the note.

   TIP: You can also type free text and use other SmartTools such as SmartPhrases and SmartLinks in conjunction with SmartText. Place your cursor where you want the text to go and begin typing or summoning your SmartTools. To learn more about documenting with SmartTools, refer to the **Use SmartTools** section.

7. Note the signing options available:

   - The default is: Sign at close encounter
   - Pend on close will prevent the encounter from being closed until your note is signed. You will also receive an In Basket reminder message that you have a pended note (My Incomplete Notes).
   - Sign on close: Lets others know this note is complete. In clinics where multiple providers are documenting in the patient's chart, this can be helpful.

   Notes that are pended or signed may still be edited or addended afterwards.

   You cannot close a scheduled encounter without a signed progress note. Keep this in mind when deciding how to sign the note.

8. Once you are finished with your note, confirm your note signing option and click **Close**. The Progress Notes section closes and the displays in read-only mode.

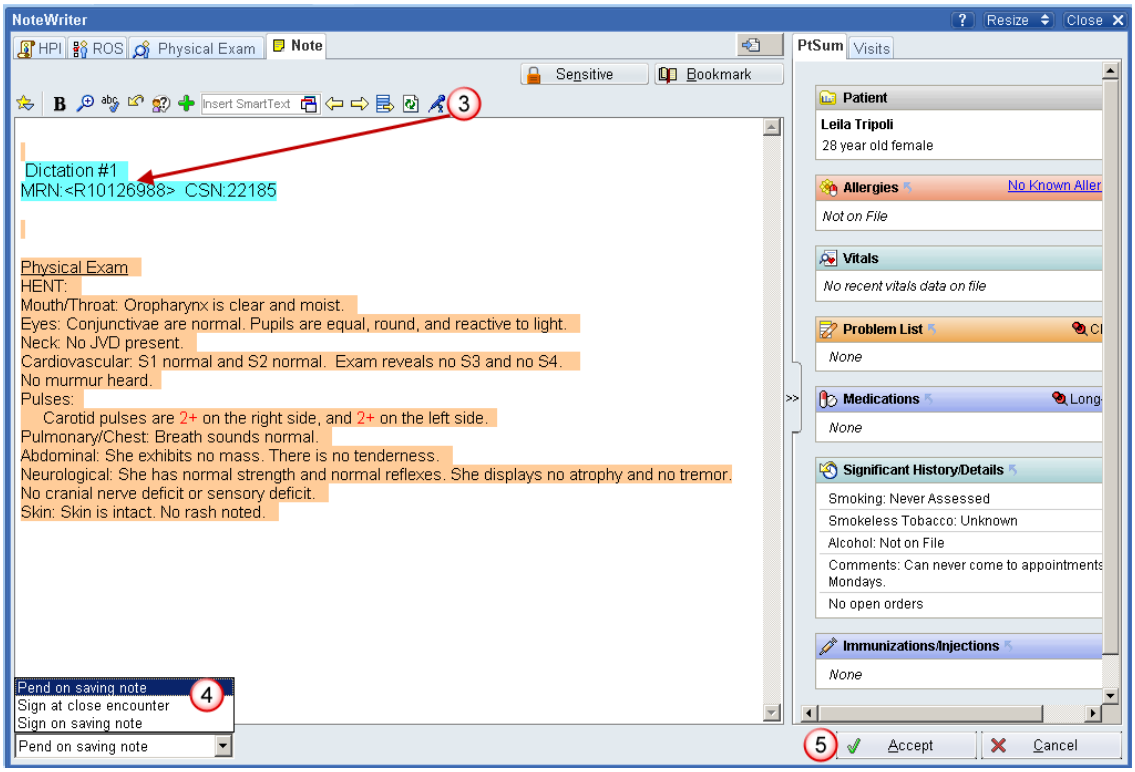
CREATE NOTE USING PARTIAL DICTATION

You can insert a tag in the progress note where the transcription of the dictation goes. The tag uniquely identifies the dictation using the patient's medical record number (MRN) or personal health number (PHN) and if appropriate a dictation number (CSN).

1. Open a progress note using one of the options outlined above.
2. While creating the note, either in the Progress Note window or the Note form of the NoteWriter, position the cursor where the transcription of the dictation is to go.
3. From the SmartTool toolbar, click the **Insert Partial Dictation** (microphone) button. A Dictation tag is inserted into the note.
4. Once you are finished with your note, confirm your note signing option.

By default Progress Notes are signed when the encounter is closed. To make further modifications to a signed note, you would have create an addendum to the note. If you want to save the note and return to it after the patient visit, change the option to ***Pend on saving note***. Another option is to ***Sign on saving note***. You cannot close a scheduled encounter without a signed progress note. Keep this in mind when deciding how to sign the note.

5. Click **Accept** to close NoteWriter.



When you close your note, a dictation message is usually routed to your administrative support pool. When the transcription has been completed it is then routed back to your In Basket for approval.

REVIEW ADDITIONAL NOTE FEATURES

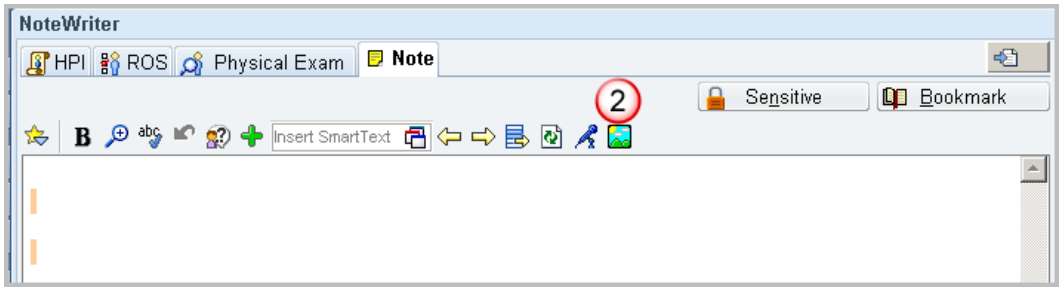
This section discusses additional progress note features such as:

- Adding an image to your note
- Taking over another's note
- Marking a note as sensitive
- Bookmarking a note

ADD AN IMAGE TO YOUR PROGRESS NOTE

You have the ability to add an image or a photograph to your progress note. For example, you might want to add a photograph of a patient's lesion to your physical exam findings.

1. Ensure that the image file is available on your computer (i.e. can be accessed from the computer's hard drive or a jump drive/memory stick).
2. From the SmartTool-enabled toolbar in your progress note, click the **Insert image** button. The Image Selector window displays.



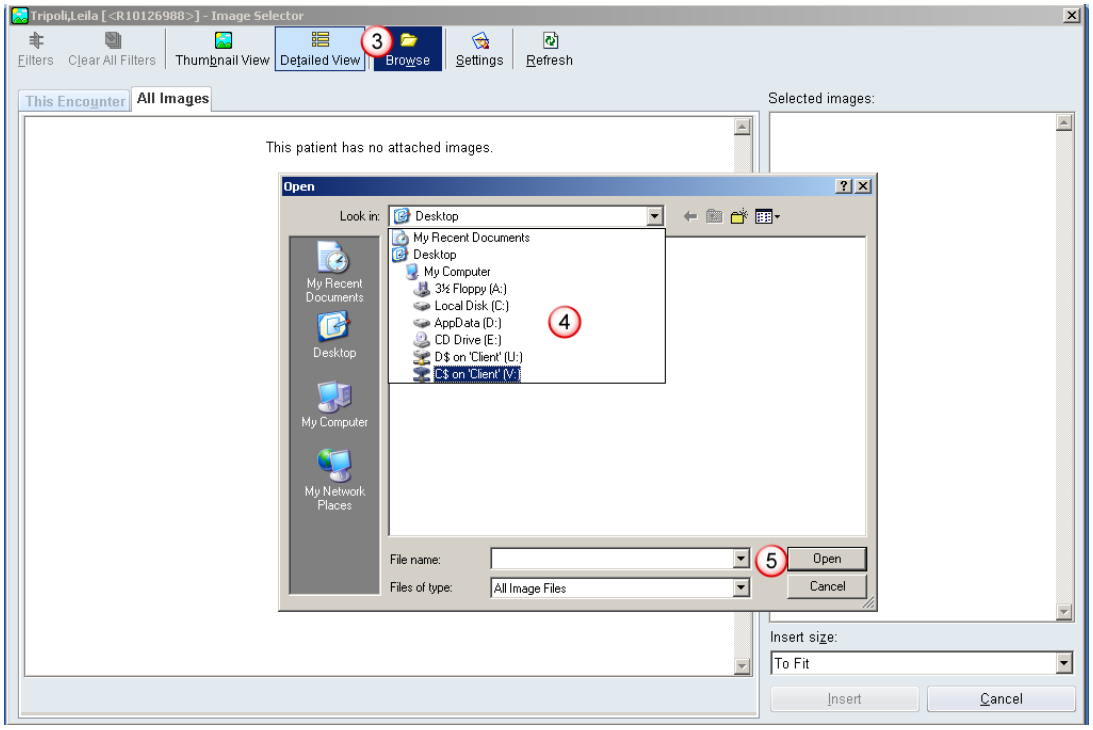
   If images have been attached to the patient's record via the Media Manager, then a list of attached files displays.

   If no images have been attached to patient's record using the Media Manager, then the message ***This patient has no attached images*** displays.

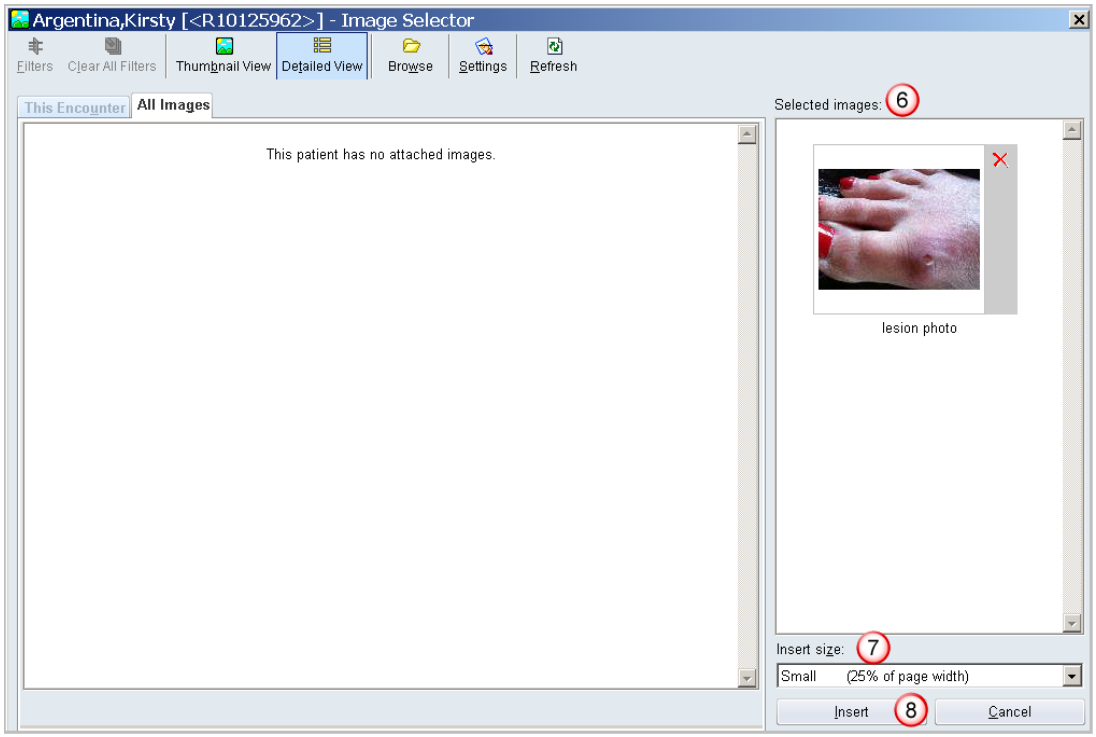
3. To attach an image to the current encounter's progress note, click **Browse**.
4. Navigate to the image stored on the computer.

   TIP 1: Remember that you are accessing ***e*CLINICIAN** via Citrix. This means that when you initially open the window to navigate to your image, the Desktop directory that you see represents the directory on the Citrix desktop. Your local computer is represented as **C$ on 'Client'**.

5. Select the image and then click **Open**.



6. The image displays in the Selected images area.
7. To adjust the image size, view the selections in the **Insert size** field.
8. To add the image to your progress note, click **Insert**. The image displays in your progress note.



TAKE OVER ANOTHER'S NOTE

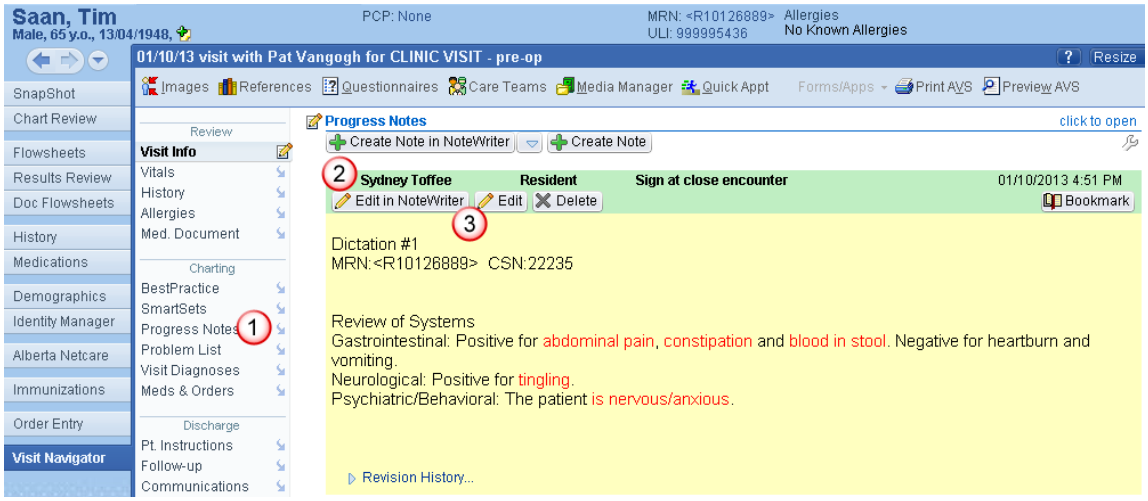
A single encounter can have multiple progress notes.

If clinical support staff or a resident starts the progress note for a visit, the physician has the option to do one of the following:

- Create their own note
- Edit the clinical support person's or resident's note, or
- Take over the note and make themselves the author.

When anyone refers to the encounter report afterwards, all of the relevant information is available regardless of the method used.

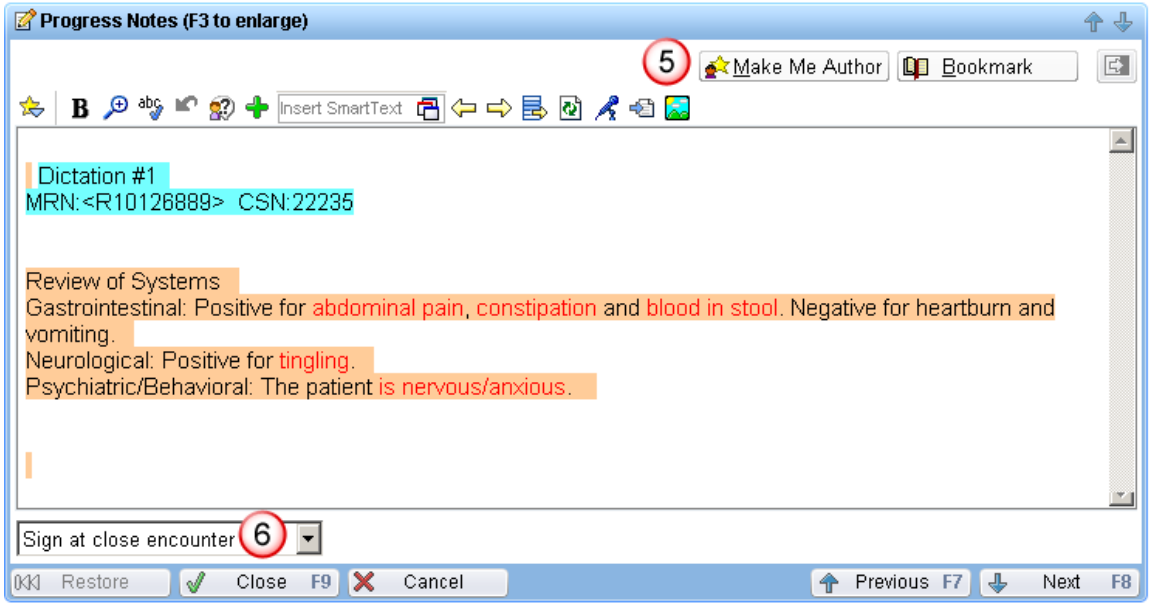
1. From the Visit Navigator, access the Progress Notes section in read-only mode (use the blue arrow).
2. Locate the note you wish to review and verify the author's name.
3. To take ownership of the note and continue the documentation, click either the **Edit in Notewriter** or **Edit** button. The first opens the existing note in NoteWriter, the second opens it in a Progress Notes window.



4. Review, edit, and complete the note.
5. Above the toolbar on the top right, c lick **Make Me Author**.
6. Once you are finished with your note, confirm your note signing option.

By default Progress Notes are signed when the encounter is closed. To make further modifications to a signed note, you would have create an addendum to the note. If you want to save the note and return to it after the patient visit, change the option to:

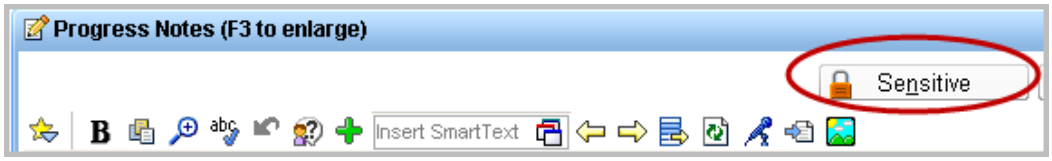
- Pend on saving note (in the NoteWriter activity)
- Pend on close (in the Progress Notes window).



7. Click **Accept** (in the NoteWriter Activity) or **Close** (in the Progress Notes window).

MARK YOUR NOTE AS SENSITIVE

You have the ability to mark a progress note as ***sensitive***. The button is accessible above the Progress Notes or NoteWriter toolbar on the far right.

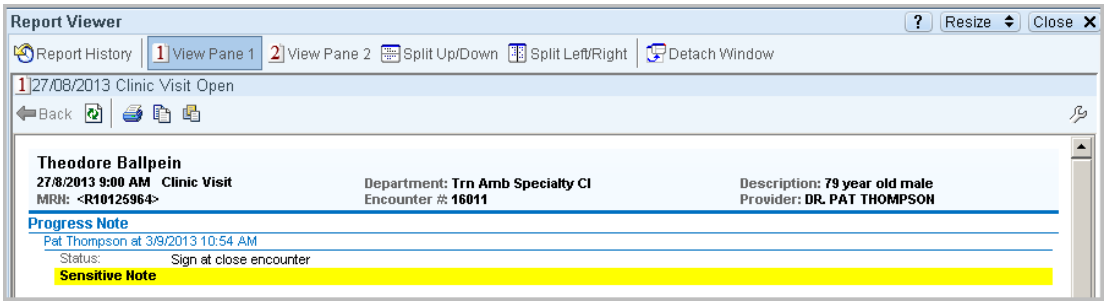


Part of the build for your clinic involved determining how sensitive notes would be handled.

Clinics can be set up to have one of the following options:

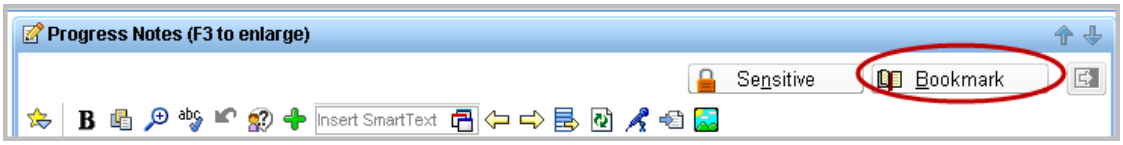
- At the provider level: The provider who signs the progress note is the only person who can see the sensitive note. This option is not recommended; if that provider leaves the clinic, no other provider can view the note.
- At the department level: Sensitive notes are viewable by all providers within the department.
- At the specialty level: Sensitive notes are viewable by all providers within the specialty, regardless of the clinic.

When progress notes are marked as sensitive they cannot be viewed by other users. This means that the note does NOT appear on the Notes tab in Chart Review. The Progress Notes section in the Encounter report displays as seen in the screenshot below.



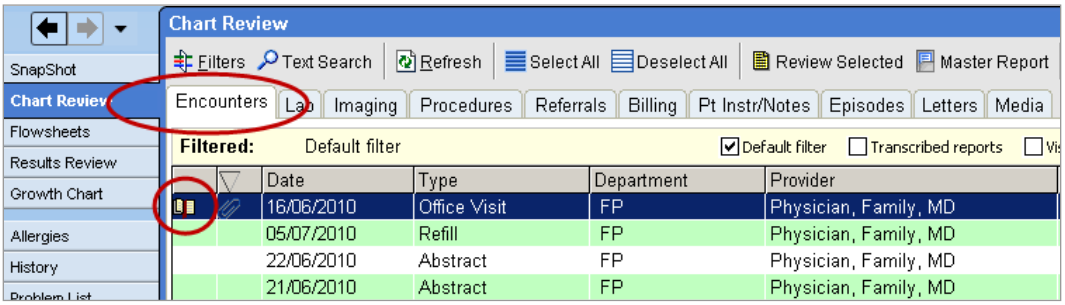
BOOKMARK YOUR NOTE

You can tag your note with a bookmark so that you can easily find relevant information for later reference.



VIEW BOOKMARKED NOTES

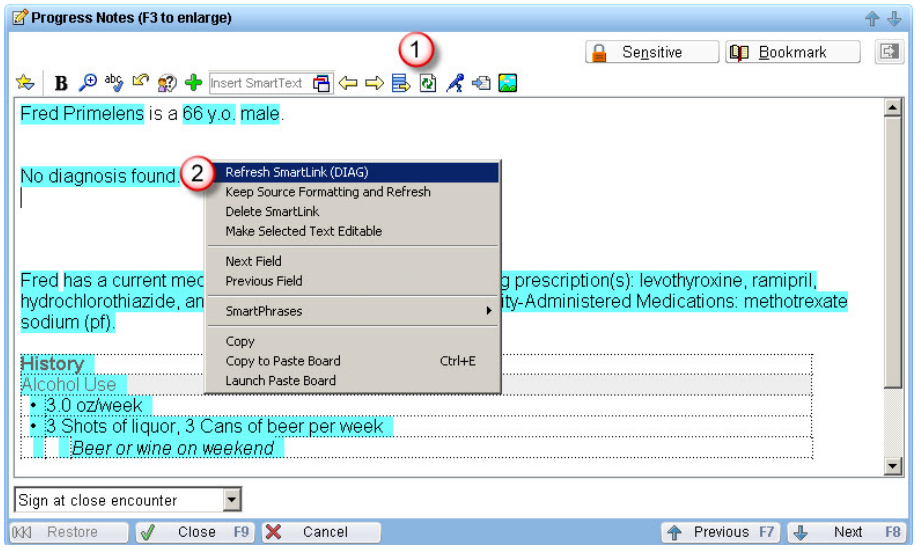
To quickly identify which progress notes are bookmarked, a bookmark icon displays beside the corresponding item on the Encounters and Pt Instr/Notes tabs in the Chart Review activity.



REFRESH SMARTLINKS IN YOUR NOTE

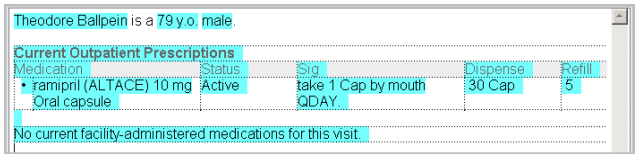
After you've updated information elsewhere in the patient's chart, you may need to return to your note and update the information in the SmartLink.

For example, your note template uses the SmartLink **.diag** to pull the encounter diagnoses into your note. If you don't update the diagnosis list until after you've written your note, you'll need to return to the note to refresh the SmartLink. A refreshable SmartLink displays with a blue background.



1. To refresh all the SmartLinks in the note, click the **Refresh** button on the SmartTool-enabled toolbar.
2. To refresh a selected SmartLink, right-click and select Refresh SmartLink.

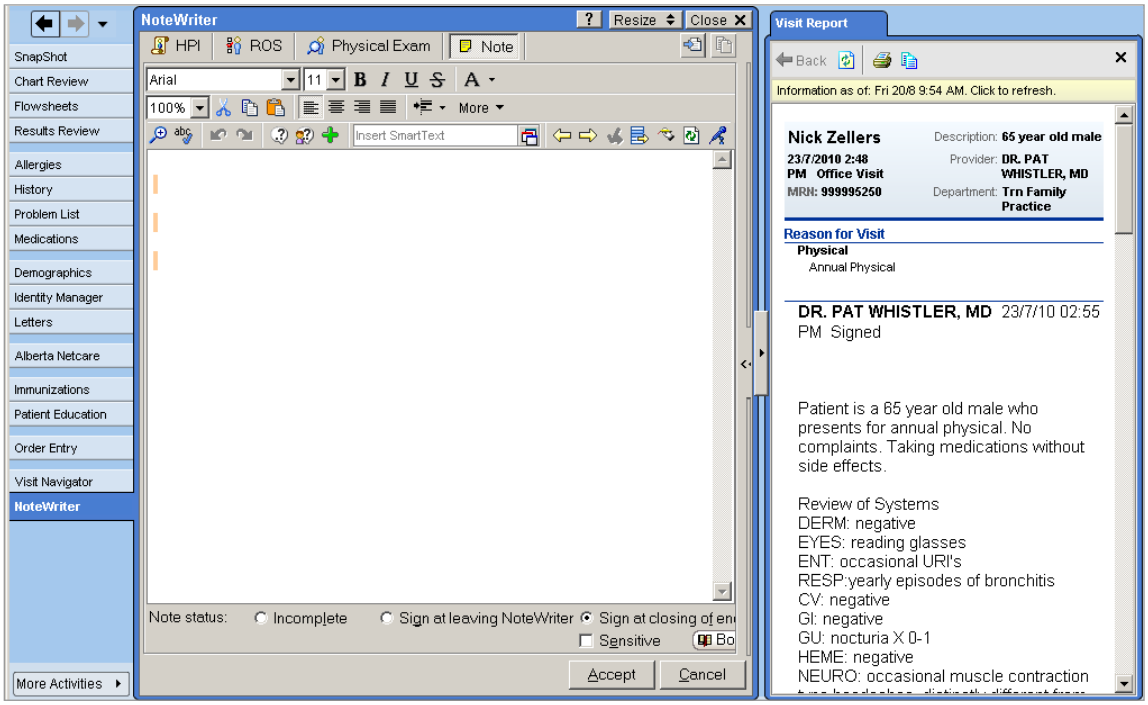
The updated information pulls into the note.



VIEW A CHART REVIEW REPORT WITH ANOTHER ACTIVITY

You can view Chart Review reports side by side with other activities such as NoteWriter. This allows you to keep pertinent information from the Chart Review activity open at all times while performing other workflows.

1. Access the Chart Review activity for the appropriate patient.
2. Select an item on a Chart Review tab.
3. To view the report in the sidebar, **right-click** the item and select Display in Chart Sidebar.
4. Open another activity, such as NoteWriter. The sidebar remains open and continues to display the added report.



TIP: This feature works best at screen resolution of at least 1280x1024.

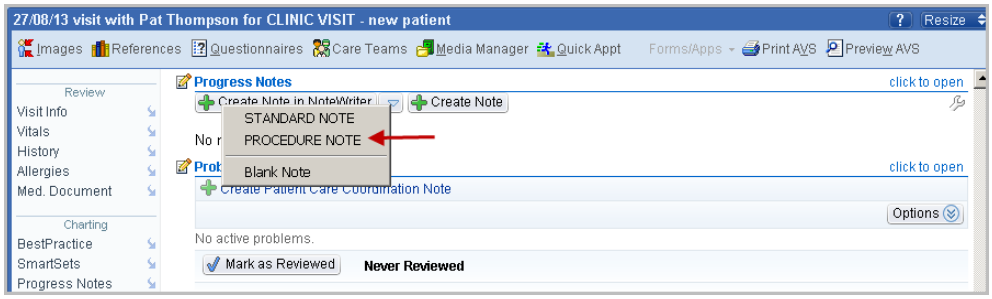
WRITE A PROCEDURE NOTE

Procedures are documented in a Progress Note within the Visit Navigator. All procedures must be documented by ordering in the Meds & Orders section.

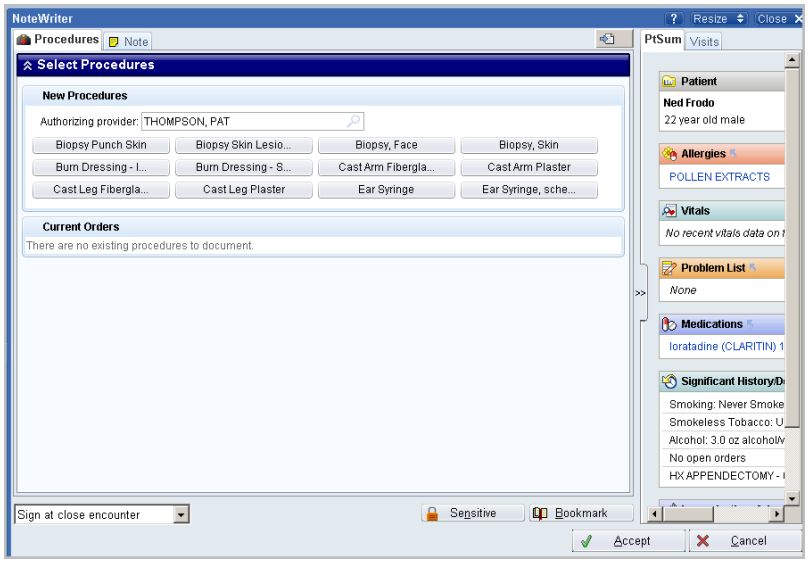
We encourage you to document the procedure in the appropriate area with the Progress Notes. This allows others using the patient's chart to quickly locate your findings in the appropriate areas.

CREATE A PROCEDURE NOTE

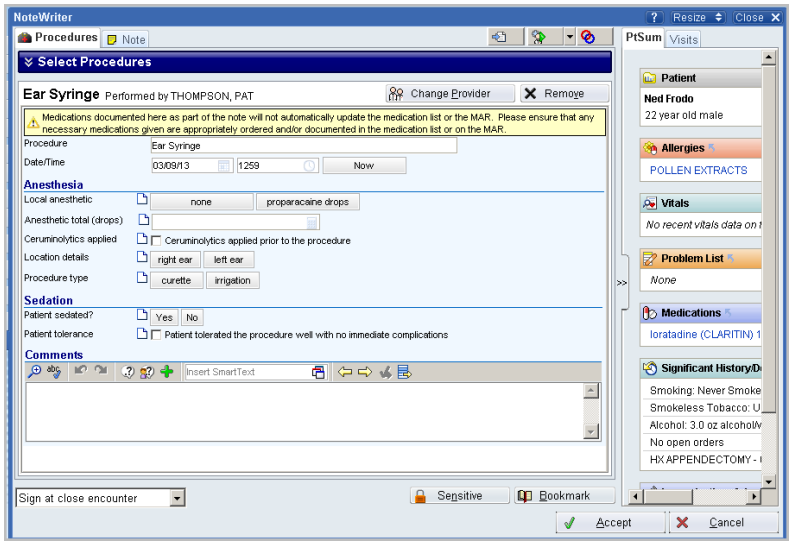
1. From the Visit Navigator table of contents, click **Create Note** in NoteWriter. Use the drop down arrow for the Procedure Note option.



The Note Tab has free text for procedure documentation. A SmartPhrase could also be used. The Procedure Tab will indicate some of the most common office procedures to choose from.



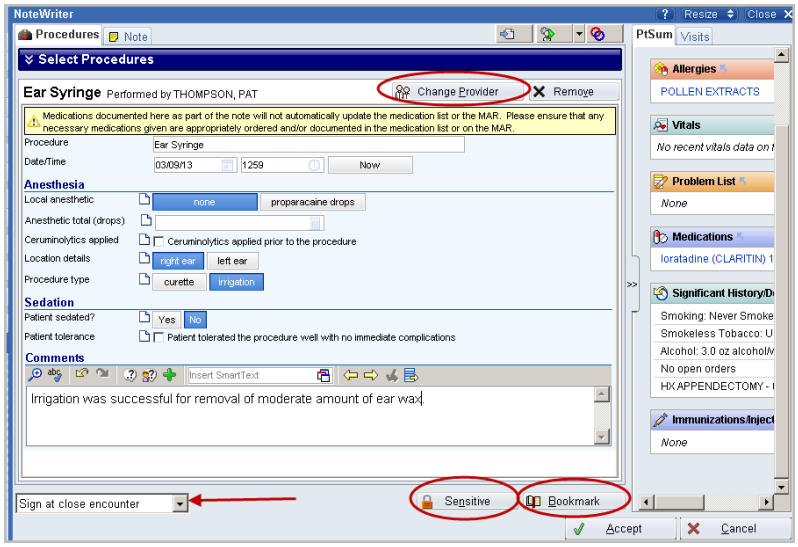
The specific procedure (example is Ear Syringe) provides a template to quickly do the documentation. If further detail is necessary there is a comment box.



If the procedure was done by another clinical staff, Change Provider would document this. A procedure can also be Sensitive and or have a Bookmark.

Select the appropriate option of Pend on saving note, Sign at close encounter or Sign on saving note.

If the procedure is not associated with an existing diagnosis, there is the option to do so in the upper right-hand corner.



The completed Procedure Note is displayed within the Progress Note Activity.

27/08/13 visit with Pat Thompson for CLINIC VISIT - new patient
Resize
Images
References
Questionnaires
Care Teams
Media Manager
Quick Appt
Forms/Apps
Print AVS
Preview AVS
Review
Visit Info
Vitals
History
Allergies
Med. Document
Charting
BestPractice
SmartSets
Progress Notes
Problem List
Visit Diagnoses
Meds & Orders
Progress Notes
click to open
Create Note in NoteWriter
Create Note
Pat Thompson
Physician
Signed
03/09/2013 11:50 AM
Addend in NoteWriter
Addend
Delete
Bookmark
Copy
Ear Syringe
Date/Time: 3/9/2013 12:59 PM
Performed by: THOMPSON, PAT
Authorized by: THOMPSON, PAT
Local anesthetic: none
Location details: right ear
Procedure type: irrigation
Patient sedated: no
Comments: Irrigation was successful for removal of moderate amount of ear wax.

RECORD VISIT DIAGNOSES, PROBLEMS AND FYIS

This chapter discusses the various ways that you can record the visit diagnoses as well as how to document and manage your patient's problem list. Included is an overview on the various types of alerts that can be added to a patient's chart.

The following main topics are covered in this chapter:

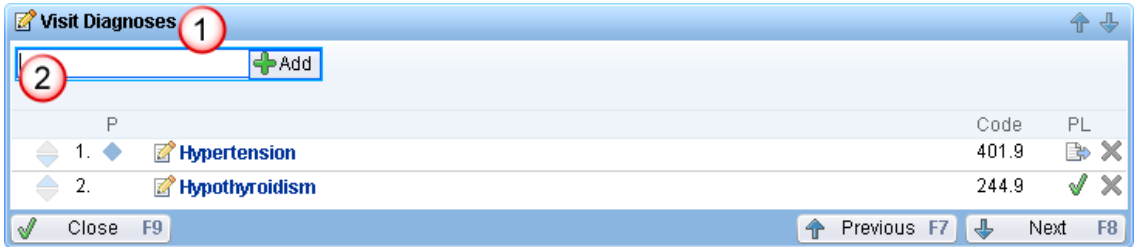
- Document Visit Diagnoses
- Manage the Patient's Problem List
- Place an Alert Flag on the Patient's Chart

DOCUMENT VISIT DIAGNOSES

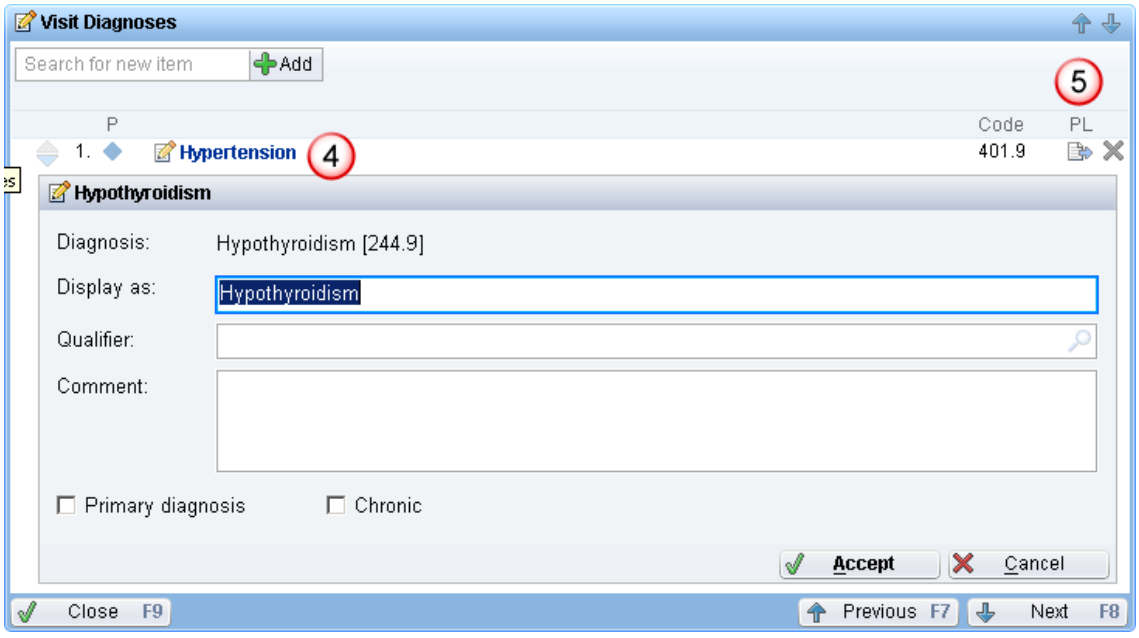
The diagnosis codes used in ***e*CLINICIAN-EMR** are ICD-9 codes (International Classification of Diseases, 9th Edition). IMO (Intelligent Medical Objects) is the name of the company who provides this data.

RECORD VISIT DIAGNOSES

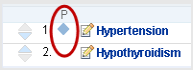
1. From the Visit Navigator table of contents, access the Visit Diagnoses section.
2. In the **Add Diagnosis** field, use completion matching to add the diagnosis and press **ENTER**.



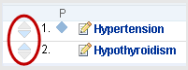
3. From the Preference List Matches or Database Matches window, select the appropriate diagnosis and click **Accept**.
4. The diagnosis displays as a hyperlink. Click the diagnosis hyperlink (or the Pencil icon) to add a Diagnosis Qualifier to each of the patient's diagnoses. Values include: active, acute, chronic, inactive, presumptive and resolved.
5. To add the diagnosis to the problem list, click the PL icon to the far right of the diagnosis.



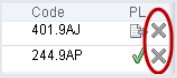
More on Visit Diagnosis Symbols



Indicates the primary diagnosis for this visit. By clicking on another row under the P column, the primary diagnosis can be changed.



You can use the up and down arrows to the left of the diagnosis to arrange an order to the list.



Click the X icon to the far right to delete the visit diagnosis.

Right-click on a diagnosis to get a list of options: Change the diagnosis, add a diagnosis to a Routine or Common preference Dx list, or promote the diagnosis to the Problem List.

MANAGE THE PATIENT'S PROBLEM LIST

A problem is defined as a medical condition that is persistent across a number of encounters (i.e., not identified and resolved in a single ambulatory encounter).

For example, Myocardial Infarction (MI) is not a good candidate for the Problem List. However, the underlying condition, Atherosclerosis, which precipitated the MI, would be appropriate. The MI episode should be recorded in the Past Medical History section.

To fully understand a patient's medical history, users must review both the active problem list and the resolved problem list. Problems like diabetes may never be resolved. Others, like pregnancy will be resolved.

The addition of items to a patient's problem list is restricted by security role. Typically only physicians, nurse practitioners, senior residents and nurses with appropriate access are given these security roles.

Sharing of a Patient's Problem List by Multiple Users

It is important that ***e*CLINICIAN – EMR** users understand the distinction between a problem list from a local EMR (maintained within a single clinic) and an enterprise wide list maintained by multiple users across multiple sites.

The use of an enterprise wide problem list is only effective if users feel comfortable with modifications made to the list by other users. Note that there is a complete audit log of all changes made to a problem list.

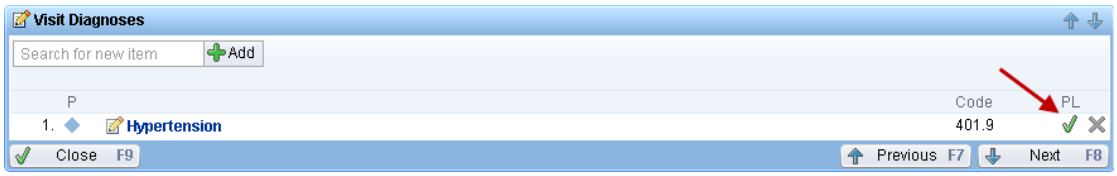
***e*CLINICIAN – EMR** cannot replace open communication between users. If multiple users have differing opinions about a problem they should work together to directly resolve the difference. This leads to improved patient care.

PROMOTE A VISIT DIAGNOSIS TO THE PROBLEM LIST

From within an encounter you have the ability to promote the visit diagnosis to the problem list.

1. From the Visit Navigator table of contents, select Visit Diagnosis.
2. In the **Add** field, completion match and select the diagnosis from the Preference List Matches window and click **Accept**.
3. Click the icon to the right of the problem.

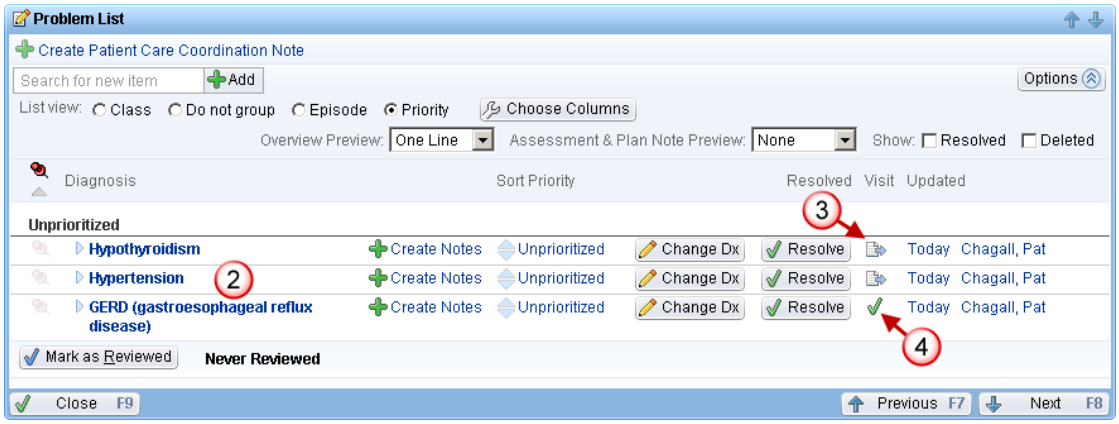
A green checkmark displays beside the problem to indicate that it has been added to the visit diagnosis list.



PROMOTE A PROBLEM FROM THE PROBLEM LIST TO THE VISIT DIAGNOSIS

From within an encounter you have the ability to promote the problem to the visit diagnosis list.

1. From the Visit Navigator table of contents, access the Problem List section.
2. Identify the problem you wish to add to the visit diagnosis list.

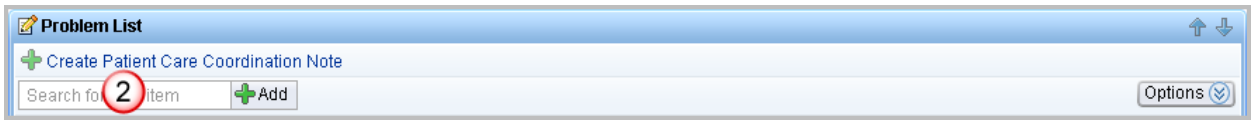


3. Click the icon to the right of the problem.
4. A green checkmark displays beside the problem to indicate that it has been added to the visit diagnosis list.

POST A PROBLEM TO THE PATIENT'S PROBLEM LIST

Diagnoses for problems that are ongoing should be placed on the patient's Problem List.

1. From the Visit Navigator table of contents, access the Problem List section.
2. In the **Search for a new item** field, use completion matching to add the problem



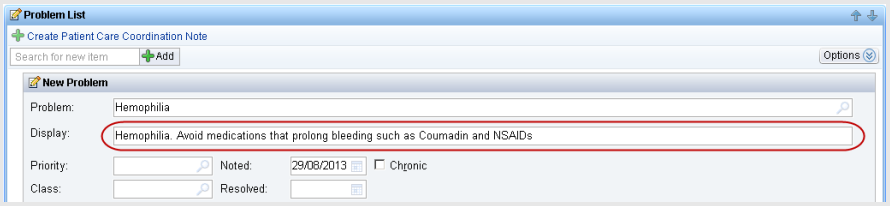
3. In the Overview section, document any necessary information.

TIP: You can use the **Display** field to add other pertinent information about the problem. The information that you record is viewable on the patient's SnapShot. Also refer to the Best Practice note which follows.

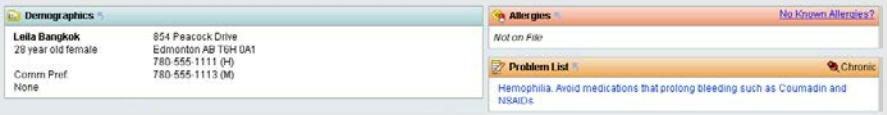
Add a Comment to the Patient's Problem List

Use the **Display** field in the Problem window to add a comment to the problem which will display in reports such as SnapShot.

For example, you might add *Avoid Medications that prolong bleeding such as Coumadin and NSAIDS* to problems associated with a bleeding disorder



You can see the advisory on the patient's SnapShot



4. If desired, assign a Priority.

   Assigning priority is not related to the seriousness of the illness. Rather, assigning priority allows you to sort the problem list so that the conditions ranked as high will always display first, medium second and so on, when you view the Problem List.

   Priorities set are specific to the user and do not affect the order set by other clinicians. Problems with a ***High*** priority display at the top of the list.

5. If appropriate, document a Patient Care Coordination Note.

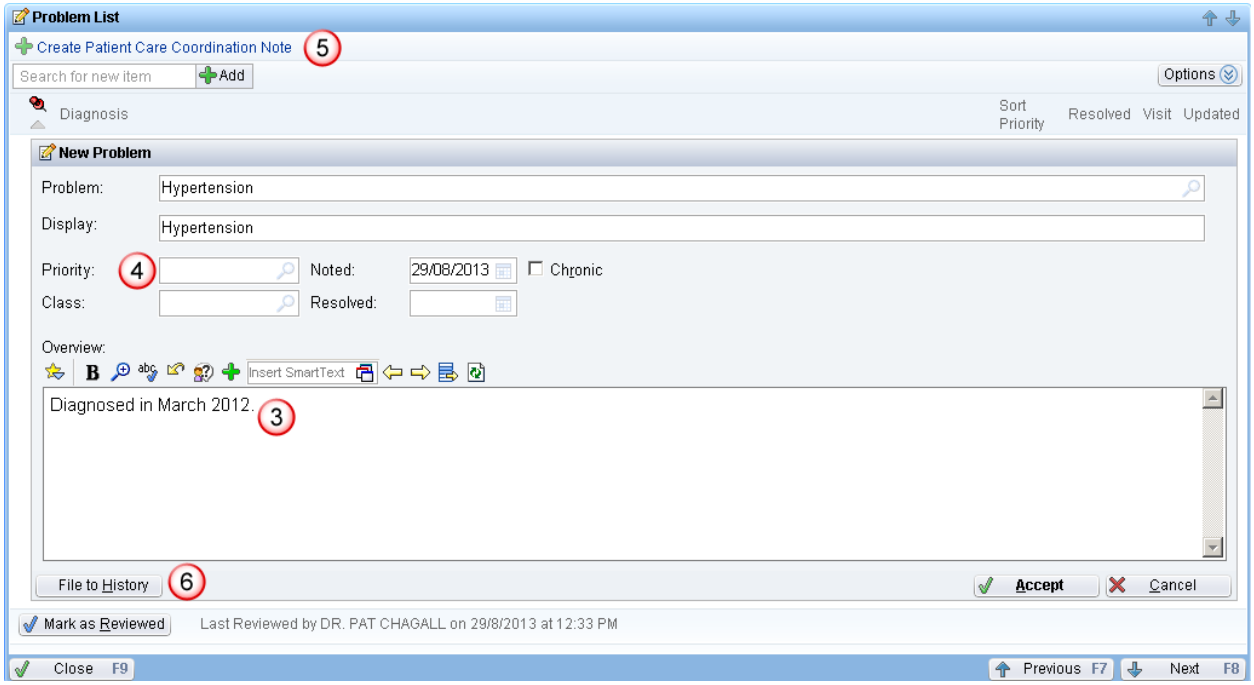
Patient Care Coordination Notes

The Patient Care Coordination note can be used to record information about the treatment the patient is receiving and general information regarding the patient's care.

The note is viewable by all providers but only one Patient Care Coordination note can be created per patient. Previous versions of this note can be viewed using the audit trail by clicking on **Past Versions** when in edit mode.

This functionality is also available from the Care Teams activity.

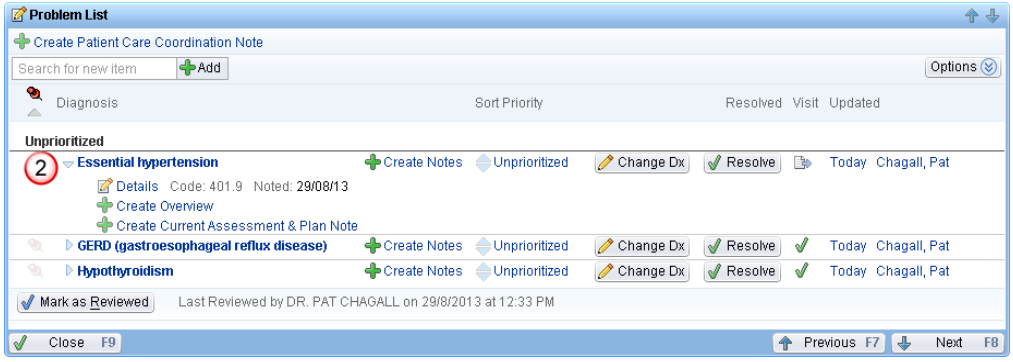
6. If appropriate, click **File to History** to add the problem to the patient's medical history.



7. When you are done, click **Accept** then click **Mark as Reviewed.**

EDIT THE PATIENT'S PROBLEM LIST

1. From the Visit Navigator table of contents, access the Problem List section.
2. Click on the problem you wish to edit.
   - To edit details such as priority and noted date, click the Details hyperlink.
   - To edit the overview note details, click the Create Overview hyperlink.
   - To add a visit note, click the Create Current Assessment & Plan Note hyperlink.
   - To resolve a problem, click **Resolve**.



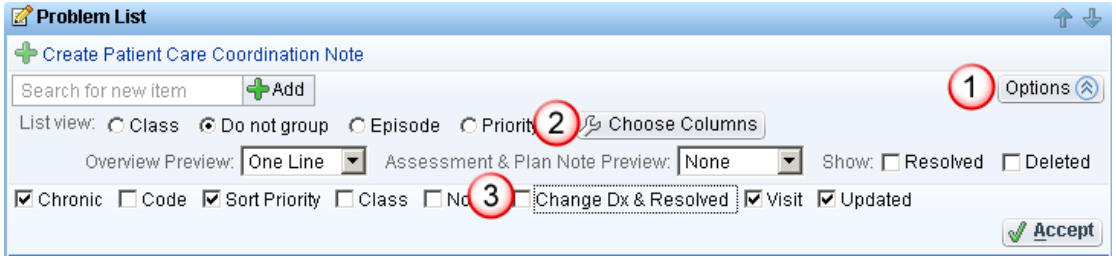
CHANGING PROBLEMS IN THE PROBLEM LIST

The **Change Dx** button allows users with the appropriate security to:

- Change an evolving problem without having to first resolve or delete it and then enter a new problem.
- Use Change Dx to access the Details form for a problem, without having to first open the problem by clicking the hyperlink.

Change Dx is not in the default view for existing users. To add the button:

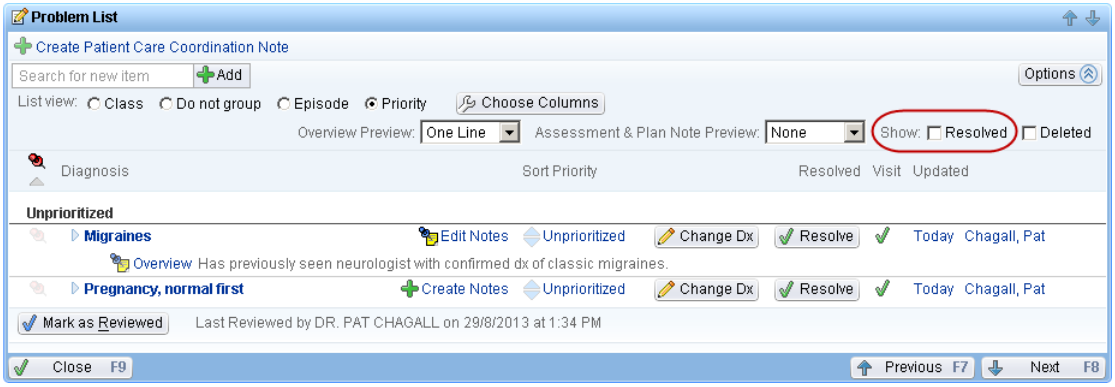
1. Click **Options**.
2. Click **Choose Columns**.
3. Select Change Dx & Resolved and click **Accept**.



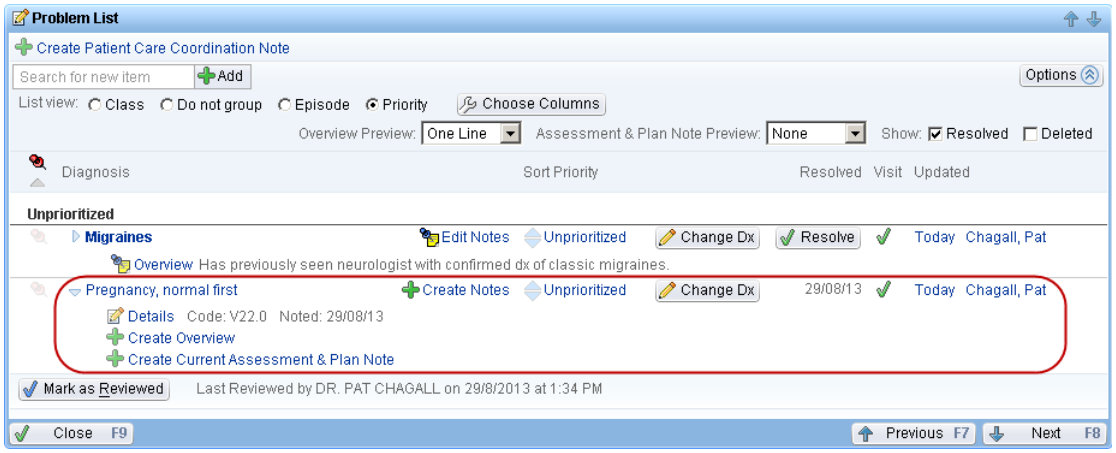
VIEW RESOLVED PROBLEMS

Over time problems may be resolved. To fully understand a patient's medical history it is important that you review both the active problem list and the resolved problem list.

1. Access either the Visit Navigator Problem List section (chart mode) or the Problem List activity (review mode) and click on the **Options** button on the upper right hand side.
2. From the upper right-hand area, in the Show area, select the Resolved checkbox.



Resolved problems display as un-bold text. You can click the Details hyperlink to view details on the resolved problem.



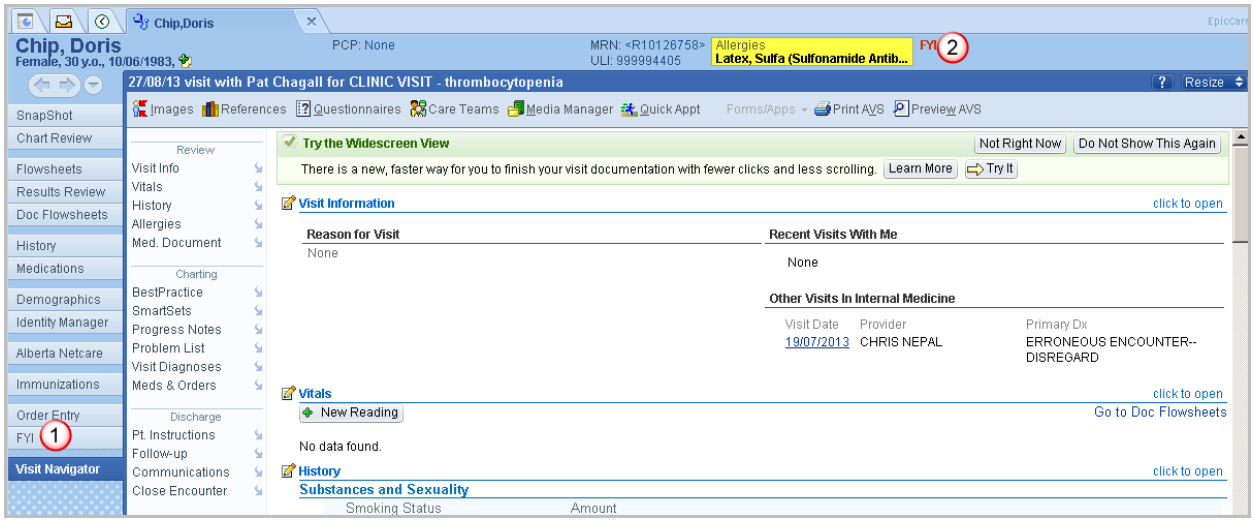
PLACE AN ALERT FLAG ON THE PATIENT'S CHART

Alert flags can be placed on a patient's chart using the FYI activity. This activity can be found in the More Activities at the bottom of the Activity Tab list.

FYI flags are categorized by flag type. Examples of FYI flag types include Disability, Communication Issue, and Latex Allergy. The ability to add, edit or see an FYI flag is controlled by user security role.

① When the patient has an FYI, the FYI activity is automatically added to the list of activities on the left-hand side of the patient's workspace.

② On the patient header, the flag is represented as a red FYI hyperlink. If you have the appropriate security level, you can hover your mouse over this hyperlink to see the FYI category. Clicking the link opens the FYI activity and allows you to quickly view the relevant information and take the appropriate actions.



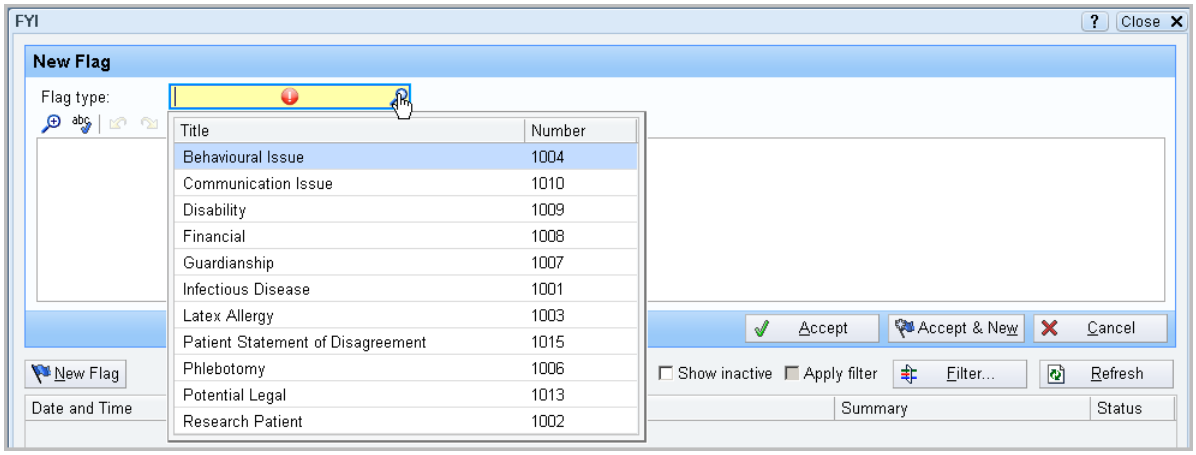
This inconspicuous way to flag a patient's record reduces the chances that a patient, or someone passing by the computer screen, might see the flag's topic.

ADD AN FYI FLAG

1. From the lower left-hand section of the patient workspace, click on the FYI activity tab.

   The FYI activity tab only displays if the patient already has an FYI. If the FYI activity tab does not display, go to More Activities, select the FYI Activity.

2. From the activity toolbar, click the **New Flag** button. The New Flag dialogue box displays.
3. In the **Flag type** field, click the **Selection** tool (magnifying glass) or use completion matching to search for the FYI flag you want to add.



4. If required, add comments.
5. When you are done, click **Accept**.
6. To view the FYI flag on the patient's header, exit and re-open the patient's workspace.

ENTER ORDERS

e*CLINICIAN - EMR** is what is known as a ***physician order entry application. This means that the functionality has been designed to facilitate the efficient entry of orders by the physician during the patient's visit. Clinical support staff and allied health professionals can also enter orders using ***e*CLINICIAN** when it is appropriate to do so.

Orders in ***e*CLINICIAN - EMR** are divided into two categories: Medications and Procedures. To prescribe a medication in ***e*CLINICIAN - EMR** you must first order it. In order to generate a requisition for a lab test or procedure, the order must be entered into the system.

The following main topics are covered in this chapter:

- General Steps for Entering an Order
- Work with Procedure Orders
- Use Order Preference Lists
- Work with Medication Orders
- Associate Orders with Diagnosis
- Sign your Orders
- Place Orders and Other Visit Details using a SmartSet
- Complete Post Order Activities

GENERAL STEPS FOR ENTERING AN ORDER

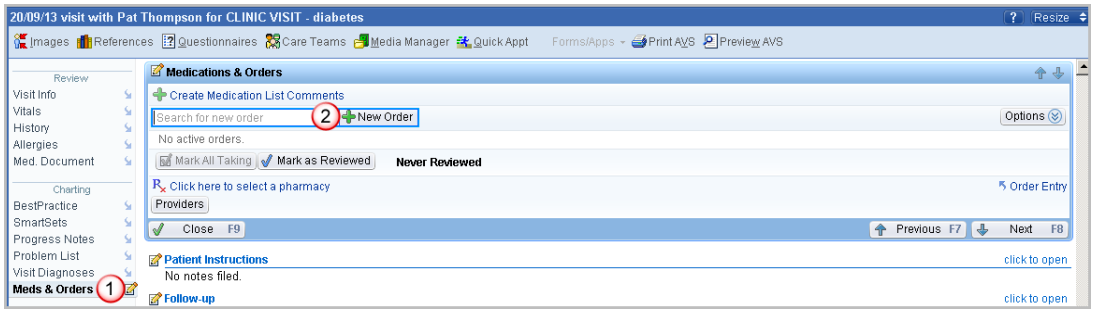
Even though there are a variety of order types, the ***basic*** steps involved are the same for all types. The example below uses a medication order to demonstrate these steps.

1. From the navigator table of contents, access the Meds & Orders section.
2. Place an order using one of the following options:
   - In the **Search for new order** field, use completion matching to add the order. Either the Preference List Search window or Database Search window displays. Remember, the system always searches the Preference List first. If it can't find any matches, it searches the system-wide Database.

   TIP 1: *e*CLINICIAN - EMR remembers your commonly placed orders and offers suggestions under the **Search for new order** field as you type.

   TIP 2: Even though the system may find matches on the Preference List, you can always manually click on the Database tab of the search window to see more matches.

   - Click **New Order**. The Preference List Browser displays. Learn more about the Preference List Browser in the topic ***Use Order Preference Lists during an encounter***.



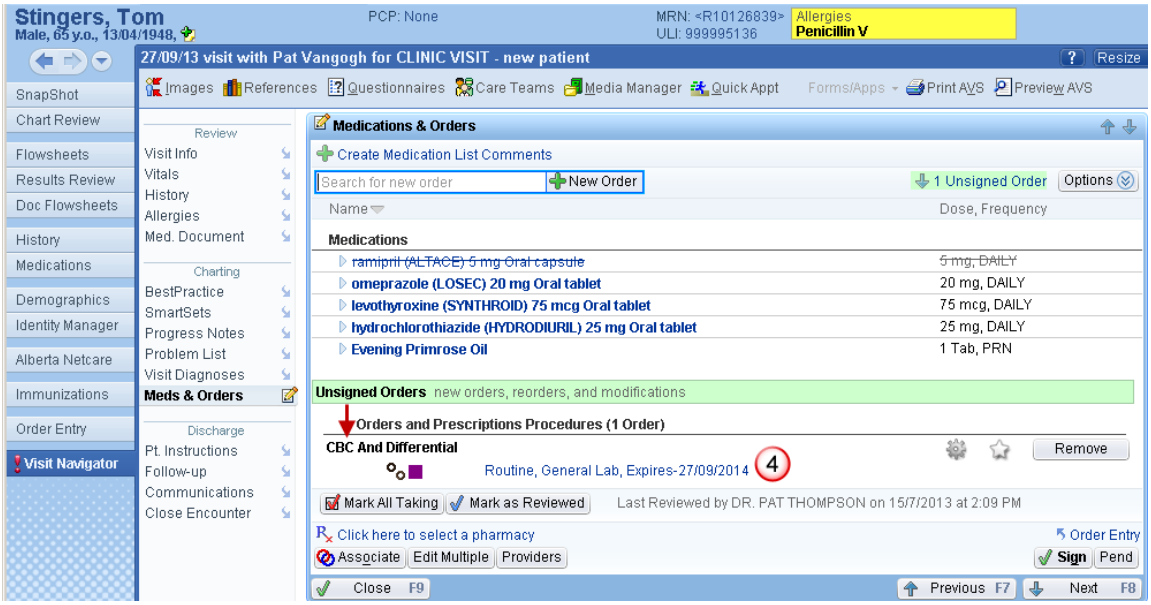
   Note: the default for the order is *Orders and Prescriptions*. If the order is administered in the clinic, you must manually select ***Clinic Administered Meds***. Refer to the Self Learning Document: ***Medication Administration Record (MAR)*** available on the AHS website, insite.

3. Select the appropriate order. The order displays as an Unsigned Order. If there is required information missing from the order, the following symbol displays beside the order.

   TIP 3: If there are multiple with missing mandatory information, you can click the **Next** button to cycle through them and complete the orders.

   TIP 4: A yield symbol indicates that recommended information is missing.

4. To view and/or edit the order, under the order name, click the Summary Sentence hyperlink.



The Order Composer displays.

The Order Composer is where you can make changes to any default values and complete additional information for the order. Depending on the type of order, different types of fields display. Also note that in some cases, a field contains both a list and buttons. The buttons represent the more common values in the list.

Subsequent topics demonstrate how to work with the Order Composer for different order types.

5. Complete the order details and then click **Accept**. The Order Composer closes.
6. Sign or pend your order(s).

WORK WITH PROCEDURE ORDERS

The following are examples of ***procedure*** orders:

- lab test
- diagnostic imaging
- clinic performed test or procedure
- immunization
- referral to a specialist or to a service
- outpatient procedure
- request for service (allows other clinic staff to schedule their own appointments) and
- billing code

The subsequent topics demonstrate how to enter some of these orders. In order to generate a requisition you must place an order for the item.

ENTER A STANDING ORDER

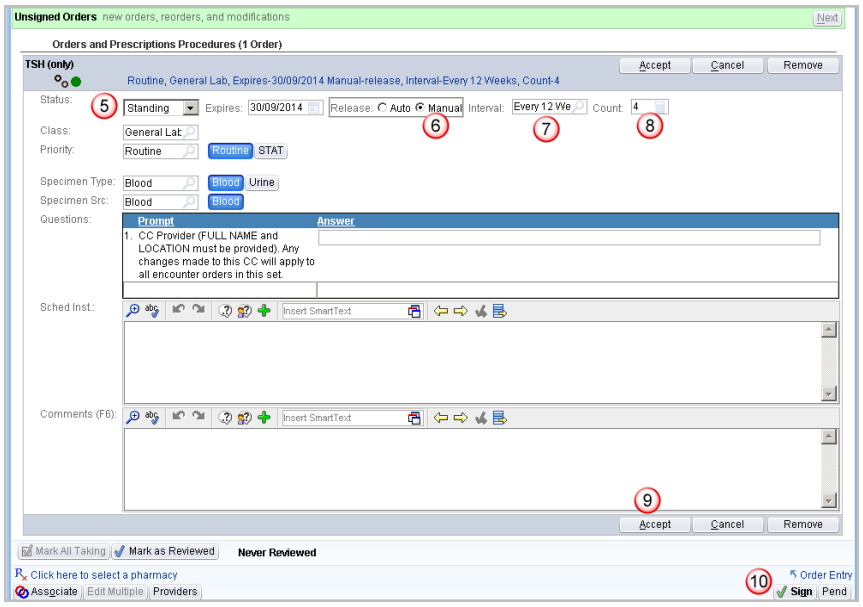
Order Statuses

In ***e*CLINICIAN - EMR** orders for lab tests have the following statuses:

- Normal - used to represent an order for a test or procedure that will be performed in the clinic that day.
- Standing –used to represent an order for a test that is placed today and repeated again at a defined interval(s).
- Future – used to represent an order that will not be completed in the clinic. This is the default status for all labs.

1. From the Visit Navigator table of contents, access the Meds & Orders section.
2. In the **Search for New Order** field, use completion matching or click **New Order**.
3. Select your order and click **Accept**. The order displays as an Unsigned Order.
4. Click the Summary Sentence hyperlink for the Order Composer to display.
5. Using the drop down menu, change the status to ***Standing***. Additional fields display to the right once you change the status to Standing
6. In the **Release** field, click **Manual**.
7. In the **Interval** field, type the period between repeats in weeks.
8. In the **Count** field, type the number of repeats.

9. In the example in the screen shot, the physician wants the patient to have a repeat TSH (only) test every 3 months for the next year. The standing order is entered with an Interval of every 12 weeks and a Count of 4.Complete the order details and then click **Accept**.
10. When you are done, Pend or Sign the order(s).



A single requisition prints for Standing Orders. The documentation of the repeat tests is handled by the receiving lab.

ENTER AN ORDER FOR AN IN CLINIC TEST

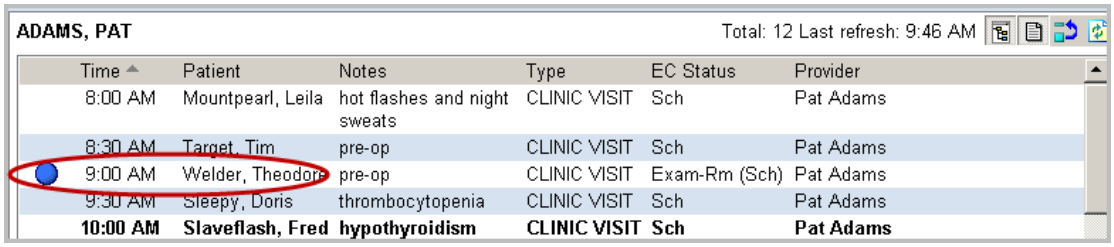
Tests that are performed in your clinic are referred to as In Clinic tests.

1. From the Visit Navigator table of contents, access the Meds & Orders section.
2. In the **Search for New Order** field, use completion matching on ***INCLINIC*** to access the lists of In Clinic tests. Continue your search for the specific the test you need. For example, ***Urine Dipstick***.

   TIP: Searching for your test may require using the Database Lookup if it is not in your Preference List.

3. If required, click the Summary Sentence hyperlink to update order details.
4. When you are finished, sign or pend your order(s).

Once the order is signed, a blue Schedule Activity flag displays beside the patient's appointment on the Schedule activity. This flag indicates that there is an In Clinic test, procedure or injection to be performed.


ADAMS, PAT
Total: 12 Last refresh: 9:46 AM
Time
Patient
Notes
Type
EC Status
Provider
8:00 AM Mountpearl, Leila hot flashes and night sweats CLINIC VISIT Sch Pat Adams
8:30 AM Target, Tim pre-op CLINIC VISIT Sch Pat Adams
9:00 AM Welder, Theodore pre-op CLINIC VISIT Exam-Rm (Sch) Pat Adams
9:30 AM Sleepy, Doris thrombocytopenia CLINIC VISIT Sch Pat Adams
10:00 AM Slaveflash, Fred hypothyroidism CLINIC VISIT Sch Pat Adams

ENTER AN ORDER FOR AN IN CLINIC PROCEDURE

In order to document that you have performed an In Clinic procedure, you must first enter an order for that procedure.

1. From the Visit Navigator table of contents, access the Meds & Orders section.
2. In the **Search for New Order** field, use completion matching on ***INCLINIC*** to access the list of In Clinic procedures. Continue your search for the specific procedure you need. For example, ***Skin Biopsy***.
3. If required, click the Summary Sentence hyperlink to update order details.
4. When you are finished, sign or pend your order(s).

> **TIP**: If appropriate to your security role, there is an option to Associate Diagnosis with the procedure.

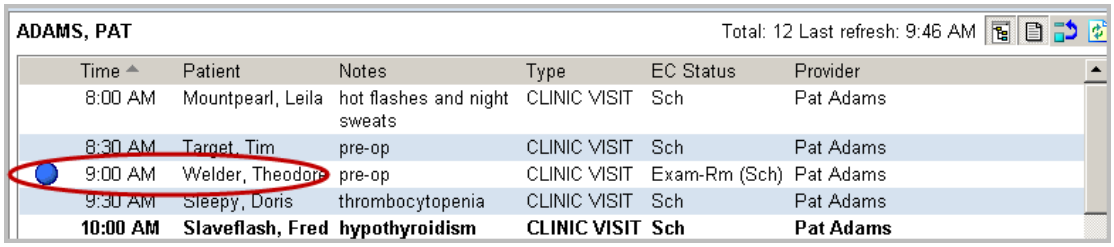
To enter a procedure note once you have performed the In Clinic procedure, refer to the topic ***Write a Procedure Note***.

ENTER AN ORDER FOR AN IMMUNIZATION

In order to document the administration of an immunization, you first must order the immunization.

1. From the Visit Navigator table of contents, access the Meds & Orders Sections.
2. In the **Search for New Order** field, use completion matching to add an immunization. For example, ***Influenza Vaccine (Seasonal Flu)***.
3. If required, click the Summary Sentence hyperlink to update order details.
4. When you are finished, sign or pend your order(s).

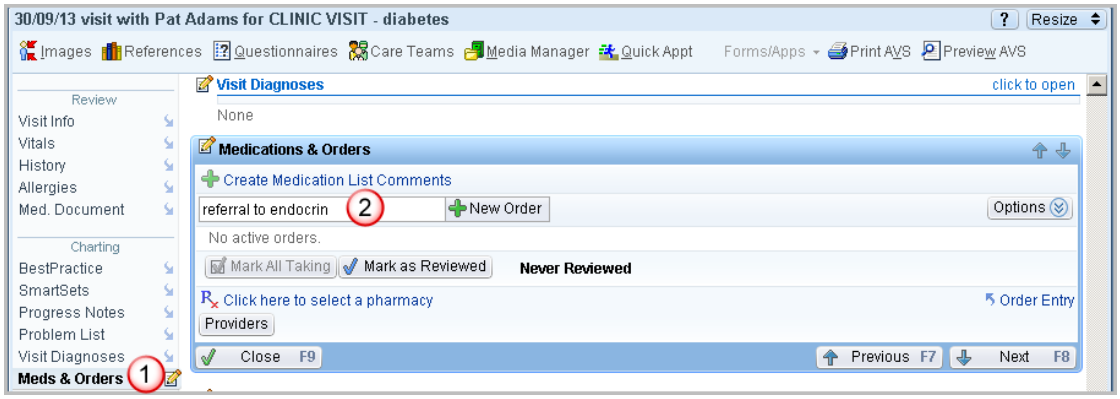
Once the order is signed, a blue Schedule Activity flag displays beside the patient's appointment on the Schedule activity. This flag indicates that there is an In Clinic test, procedure or injection to be performed.


ADAMS, PAT
Total: 12 Last refresh: 9:46 AM
Time
Patient
Notes
Type
EC Status
Provider
8:00 AM Mountpearl, Leila hot flashes and night sweats CLINIC VISIT Sch Pat Adams
8:30 AM Target, Tim pre-op CLINIC VISIT Sch Pat Adams
9:00 AM Welder, Theodore pre-op CLINIC VISIT Exam-Rm (Sch) Pat Adams
9:30 AM Sleepy, Doris thrombocytopenia CLINIC VISIT Sch Pat Adams
10:00 AM Slaveflash, Fred hypothyroidism CLINIC VISIT Sch Pat Adams

Refer to the Self Learning Document: ***Document an Immunization or Vaccine Administration Visit.***

ENTER AN ORDER FOR A REFERRAL

1. From the Visit Navigator table of contents, access the Meds & Orders section.
2. In the **Search for New Order** field, use completion matching to add a referral. For example, ***referral to endocrinology***.

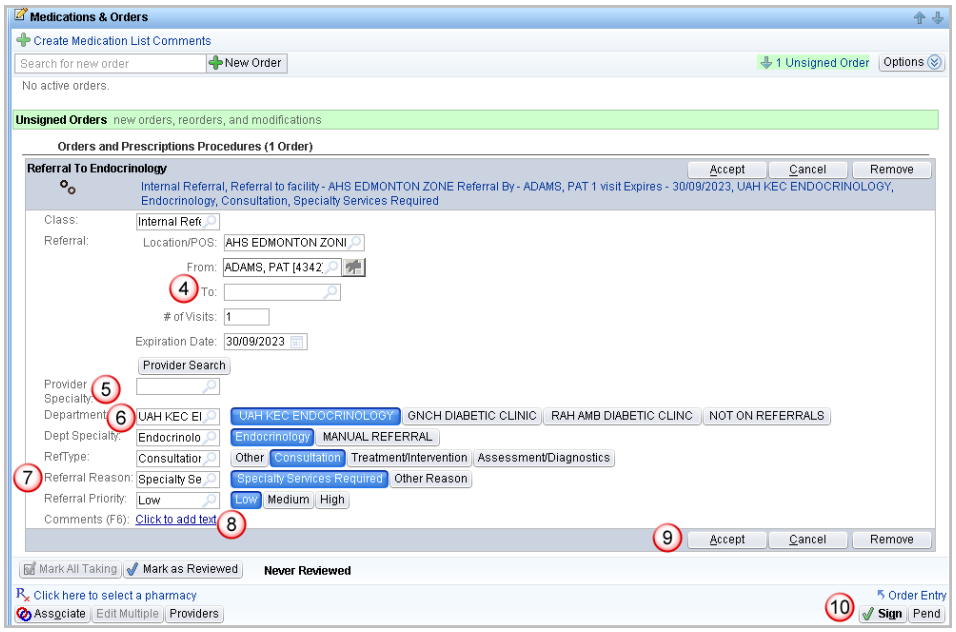


3. In the Unsigned Orders, click the Summary Sentence to open the order details.
4. If you know the name of the specialist that you want to refer the patient to, navigate to the **To** field. Use the **Selection** tool or type the name using ***lastname, firstname*** format. Otherwise leave the field blank.
5. Optional step: If referring to another clinical discipline, navigate to the **Provider Specialty** field and enter the speciality name.
6. Optional step: If referring to a department (clinic), navigate to the **Department** field and use the **Selection** tool or buttons to choose the appropriate department. This may already be selected for you based on the type of referral that you ordered. Or you can select the appropriate location for the speciality referral with available buttons.
7. Update the **Ref Type Referral Reason**, and **Referral Priority** fields with available buttons.

If the referral is to a department or clinic that is outside of ***e*CLINICIAN** the Department and Dept Specialty fields will have optional buttons available. The fields may be pre-populated or default to:

- Department = NOT ON REFERRALS
- Dept Specialty = MANUAL REFERRAL

8. From the Click to add text hyperlink you can record any additional information as comments. These comments display in the Notes/History section on the Referral record.
9. Click **Accept**.
10. Click **Sign**. A referral record is generated and becomes available in the ***e*CLINICIAN** Referral module where it can be tracked.



ENTER A BILLING ORDER (DROP A BILLING CODE)

When an appointment is made in ***e*CLINICIAN–Scheduling** the appointment details are sent to ***e*CLINICIAN – Billing**. Unscheduled encounters such as Orders Only encounters and Telephone encounters also send information to ***e*CLINICIAN–Billing**. Billing codes can also be entered directly in to ***e*CLINICIAN-Billing**.

Billing codes are entered into ***e*CLINICIAN-EMR** through the Medications & Orders section. If billing and diagnostic codes are entered, the details are added to the patient's record in ***e*CLINICIAN – Billing** and then be billed to the appropriate payer.

Use completion matching or the preference list to select the appropriate billing codes.

Billing codes include:

- Alberta Health & Wellness Service (Fee) Codes

- Third party service codes including: Patient, WCB and Department of Defense
- Patient/Direct Billing codes for services not covered by Alberta Health & Wellness

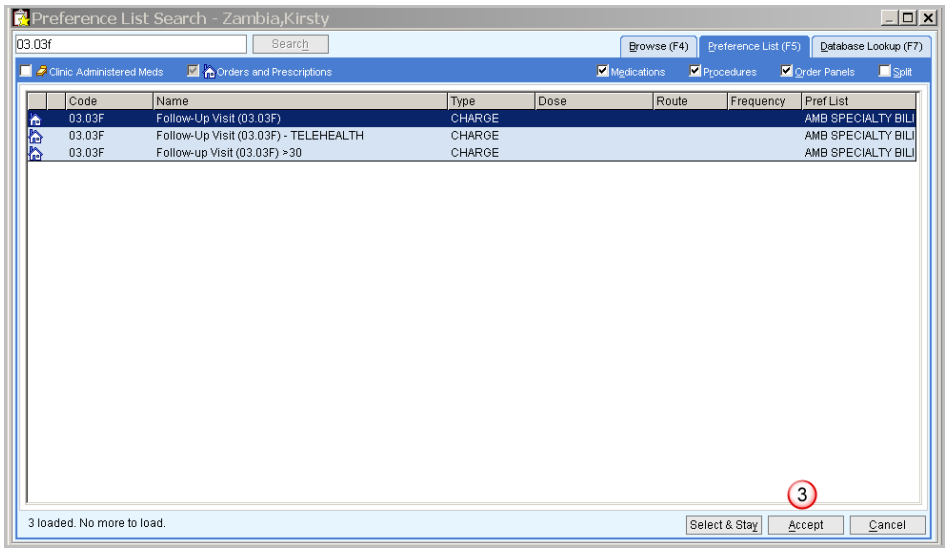
Billing codes can also be entered directly in to ***e*CLINICIAN-Billing**.

1. From the Visit Navigator table of contents, access the Meds and Orders Section.
2. Click **New Order** and use the Browse tab to access the Billing section.

3. Option: Use completion matching with appropriate billing code(s) to search your Preference List.

Billing codes within the ***e*CLINICIAN** are only the Alberta Health & Wellness Service (Benefit) Codes.

4. Select your billing code(s) and click **Accept**. The order displays as an Unsigned Order.
5. All billing orders are marked as Sensitive, so only you have access to this information. Further details on ***Mark your Note as Sensitive*** are on page 119.



6. Click the Summary Sentence hyperlink. The Order Composer displays.
7. Complete the appropriate details around Quantity and Modifiers. The encounter diagnosis displays as the Visit Diagnosis.
8. Supportive documentation to Alberta Health and Wellness is captured in the Questions fields and comments to billing staff can be added.
9. Click **Accept**.
10. Pend or sign your orders.

CORRECT A BILLING CODE AFTER IT IS SUBMITTED

1. From the schedule activity, locate the patient's appointment where the incorrect billing code was ordered.
2. With the patient's appointment highlighted, double-click.
3. The Encounter is Closed message should display.
4. Click Create Addendum.
5. Access the Meds and Orders section.
6. In the **Search for New Order** field, enter the correct billing code, or click **New Order** to search the preference list.
7. Select and accept the appropriate billing code.
8. Click **Sign**.
9. To associate the billing code to a single diagnosis, click **Yes.**
10. To choose from multiple visit diagnoses, click **No** and select the appropriate diagnosis.
11. From the Visit Navigator table of contents, select Sign Addendum.
12. Click Sign Addendum.
13. The new billing code has been sent to the billing team for processing.
14. Note: it is not possible to remove the original billing code from the patient's chart and it will remain visible in Chart Review, under the Billing tab. It will be removed from the billing application.

WORK WITH MEDICATION ORDERS

INTRODUCTION TO DISCRETE SIGS

Prior to ***e*CLINICIAN - EMR**, when you handwrote a prescription, you wrote a sentence which described how much of the medication the patient should take, as well as how it should be taken and how often to take it. For example, ***Take 1 tablet twice a day***.

When ordering prescriptions in ***e*CLINICIAN - EMR**, you are now required to enter this information into specific fields such as **Dose**, **Route**, **Frequency**, and **Dispense**, using the Order Composer.

When working with each of these fields, you'll select from a list of predefined values. From the information entered into these fields, ***e*CLINICIAN - EMR** automatically combines this information and generates the prescribed sig.

By entering this information as a ***discrete sig***, you will see the following benefits:

- **Enhanced dose checking -** Alerts display when the dose falls outside of allowed values for dose, frequency, duration of therapy, patient age, and weight.
- **More convenient weight-based dosing -** You can easily order a weight- or BSA-based medication and change the calculation with minimal clicks in the Order Composer.

About First Data Bank (FDB) Canada

First Data Bank (FDB) Canada is the source for the allergy and medication information used in ***e*CLINICIAN - EMR.**

A new source file is received from FBD weekly and uploaded into ***e*CLINICIAN – EMR**.

PLACE A MEDICATION ORDER

Medications are ordered using the Medications & Orders section in a number of different navigators.

1. From the navigator table of contents, select Meds & Orders.
2. In the **Search for new order** field, use completion matching to search for the medication.

Search for Medications Quickly

You can search for medications by typing the first three letters of the name, a space, and then the dose.

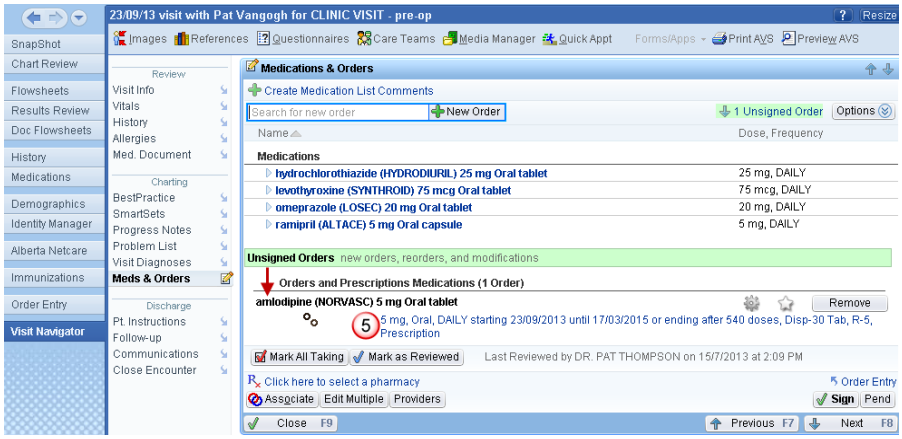
- For example, type **pen 300**

Optionally you can also type a space after the dose and then the form of the medication.

- For example, type **pen 300 t**

A search window displays with a list of records matching your search.

3. Select the appropriate record.
4. Click **Accept**. One of the following happens:
   - If the medication record is completely pre-built with all the mandatory information entered, the order displays under the Unsigned Orders section. If this is the case, follow the remaining steps.
   - If the medication record contains unpopulated mandatory fields, the Order Composer displays, highlighting the areas that require attention with red stop signs. To learn more about managing these fields, refer to the next topic ***Working with the Medications Order Composer***.
5. Review the Summary Sentence. If you wish to modify the sig, click the Summary Sentence to launch the Order Composer. If not, proceed to step 7.



6. Update order details as required and click **Accept**. The Order Composer closes.

7. Sign or pend your order(s).

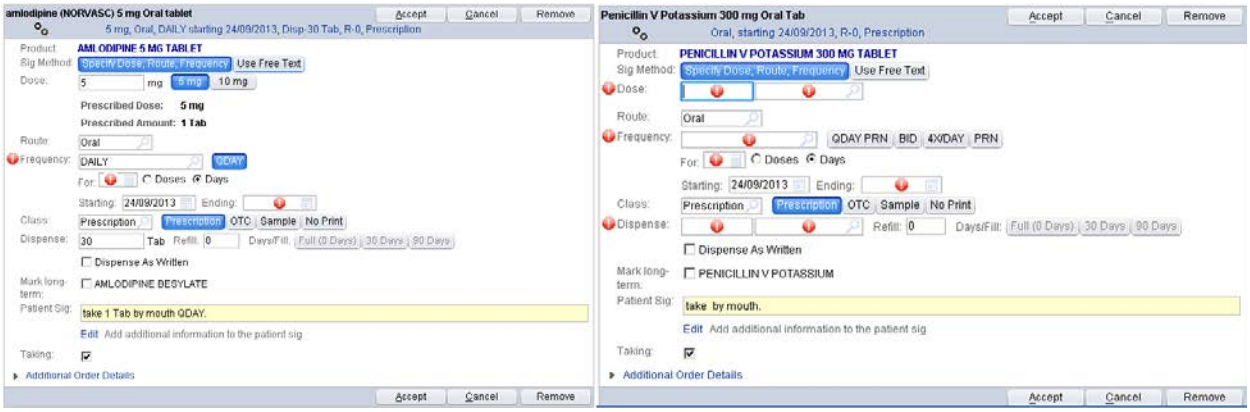
Add Medications to Personal Preference List

If this is a medication you prescribe regularly, and with the same patient sig, before signing, consider adding this to your personal preference list. To learn more about this, refer to the topic **Save a Medication Order to your Personal Preference List During an Encounter**.

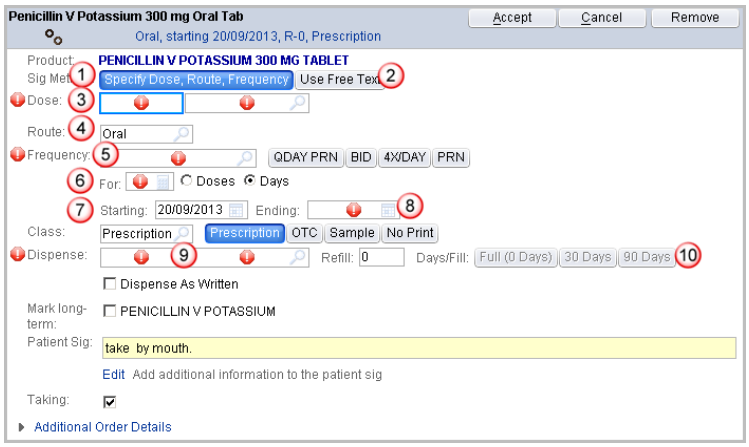
WORKING WITH THE MEDICATIONS ORDER COMPOSER

The Order Composer is where you can make changes to any default values and add additional or mandatory information for the order. It displays automatically after placing an order if mandatory information is missing (indicated by red stop signs). You can also access it manually by clicking the Summary Sentence hyperlink below the order name.

For some medication records, such as the amlodopine many of the required fields auto-populate because these values were built into the medication record. Compare this with penicillin where all of the fields are empty (see below).


amlodipine (NORVASC) 5 mg Oral tablet
Accept
Cancel
Remove
5 mg, Oral, DAILY starting 24/09/2013, Disp-30 Tab, R-0, Prescription
Product: AMLODIPINE 5 MG TABLET
Sig Method: Specify Dose, Route, Frequency | Use Free Text
Dose: 5 mg | 5 mg | 10 mg
Prescribed Dose: 5 mg
Prescribed Amount: 1 Tab
Route: Oral
Frequency: DAILY | QDAY
For: Doses Days
Starting: 24/09/2013 Ending:
Class: Prescription | Prescription | OTC | Sample | No Print
Dispense: 30 Tab Refill: 0 Days/Fill: Full (0 Days) | 30 Days | 90 Days
Dispense As Written
Mark long-term: AMLODIPINE BESYLATE
Patient Sig: take 1 Tab by mouth QDAY.
Edit Add additional information to the patient sig
Taking:
Additional Order Details
Penicillin V Potassium 300 mg Oral Tab
Oral, starting 24/09/2013, R-0, Prescription
Product: PENICILLIN V POTASSIUM 300 MG TABLET
Sig Method: Specify Dose, Route, Frequency | Use Free Text
Dose:
Route: Oral
Frequency: QDAY PRN | BID | 4X/DAY | PRN
For: Doses Days
Starting: 24/09/2013 Ending:
Class: Prescription | Prescription | OTC | Sample | No Print
Dispense: Refill: 0 Days/Fill: Full (0 Days) | 30 Days | 90 Days
Dispense As Written
Mark long-term: PENICILLIN V POTASSIUM
Patient Sig: take by mouth.
Edit Add additional information to the patient sig
Taking:
Additional Order Details

The Order Composer has several distinct areas with which you should become familiar:


Penicillin V Potassium 300 mg Oral Tab
Accept
Cancel
Remove
Oral, starting 20/09/2013, R-0, Prescription
Product: PENICILLIN V POTASSIUM 300 MG TABLET
1 Sig Met
Specify Dose, Route, Frequency
Use Free Text
2
3 Dose:
4 Route: Oral
5 Frequency:
QDAY PRN | BID | 4X/DAY | PRN
6 For: Doses Days
7 Starting: 20/09/2013 Ending:
8
Class: Prescription | Prescription | OTC | Sample | No Print
9 Dispense:
Refill: 0 Days/Fill: Full (0 Days) | 30 Days | 90 Days
10
Dispense As Written
Mark long-term: PENICILLIN V POTASSIUM
Patient Sig: take by mouth.
Edit Add additional information to the patient sig
Taking:
Additional Order Details

① **SPECIFY DOSE, ROUTE, FREQUENCY BUTTON**: This is the default display for the order composer and requires that dose, route, and frequency as well as the start date, end date, and dispense and refill values be entered as discrete date.

② **USE FREE TEXT BUTTON**: You can enter dose, route, and frequency as free text, using the **Patient Sig** field. Note: the start date, end date, and dispense and refill values must still be entered as discrete data.

③ **DOSE FIELDS**: This information is automatically generated for you if the data was built into the medication record. Otherwise, there are two dose fields. The first is for entering the numeric value associated with the dose and the second is for the unit of measure (e.g. capsule, tablet, mg). If only one unit is allowed, the second field is not editable. You must complete the first field before you can complete the second.

> **TIP 1**: You can type both the number and unit in the first field and the system automatically separates them out.
>
> **TIP 2:** If you enter a dose that is not easily divisible based on the unit that was ordered (e.g. a dose of 7.5 mg using a 10 mg tablet), the system issues a warning and adjusts the sig, rounding the dose to better match the ordered product. It may be preferable to cancel the order and use a medication record with a dose value more conducive to dividing/multiplying, such as a 2.5 mg tablet, in this example.

④ **ROUTE FIELD**: Indicates the method for taking the medication.

⑤ **FREQUENCY FIELD**: Indicates how often the patient is to take the medication.

⑥ **FOR FIELD**: Indicates the duration of the prescription in either doses or days. This field assists with auto-calculating both the ending date and dispense and refill values when the Dose data is built into the medication record.

⑦ **STARTING FIELD**: This is a date field which auto-populates with the date at the time of the order. This field is editable if you want to change it.

⑧ **ENDING FIELD**: This is a date field. Depending on the frequency you choose and how the medication record was built, the field behaves differently:

- The data auto-calculates provided that the a) **Frequency** and **For** fields are complete, b) the Dose value was pre-built in the medication record and c) the frequency is not ***PRN*** or ***CONTINUOUS***.
- You must manually enter an ending date for prescriptions that have a frequency of ***PRN*** or ***CONTINUOUS***.
- An ending date is not required for medications that have a frequency of ***Once***.

> **TIP 3:** You can use date shortcuts in this field where t=today, w=week, m=month and y=year. E.g. an end date of 6 months from now can be entered as m+6.

⑨ **DISPENSE FIELDS**: There are two dose fields. The first indicates what portion of the prescription is to be initially assigned (versus the portion to be assigned as refills). The second

field is the unit of measure (e.g. capsule, tablet, mg). You must complete the first field before you can complete the second.

TIP 4: You can type both the number and unit in the first field and the system automatically separates them out.

⑩ **DAYS/FILL BUTTONS**: These buttons assist you with assigning dispense and refill values. They are only available if a) **Frequency** and **For** fields are complete, b) the Dose value was pre-built in the medication record and c) the frequency is not ***PRN*** or ***CONTINUOUS***. You have three options available to you:

- **Full (# Days)** button – reflects the day or dose count you specified and is assigned entirely to **Dispense** field. E.g. for a 180 day prescription: Dispense=180, Refill=0.
- 30 Days – a default button which assigns 30 to the **Dispense** field and the rest to **Refill**, as refills of 30. E.g. for a 180 day prescription: Dispense=30, Refill=5.
- 90 Days – a default button which assigns an initial dispense of 90 and the rest as refills of 90. E.g. for a 180 day prescription: Dispense=90, Refill=1.

TIP 5: If there are details you want to add to the sig which cannot be added in discrete fields, you can enter this information as free text by clicking the Edit hyperlink in the Patient Sig area.

Why Enter End Dates for Medications?

Entering End Dates for medication orders is likely a new concept if you haven't used an electronic medical record previously. The date itself is a **soft date**, meaning that you have no control over when the patient might actually fill the prescription and then start to take it.

This date ensures that accurate medication lists are maintained on all patients in ***e*CLINICIAN - EMR**. When an End Date is reached, the medication is automatically removed from the patient's current medications list, so the medication list is always current and no one has to manually clean it up.

The only exception to this rule is for **Long Term** medications. Medications that are marked as Long Term remain on the current medications list even after the end date is reached.

ENTER AN ORDER FOR A MEDICATION NOT AVAILABLE IN *e*CLINICIAN

As previously stated, First Data Bank (FDB) Canada is the medication source for ***e*CLINICIAN - EMR**. The list of medications provided by FDB is not exhaustive. For example, it does not contain all brands and forms of multi-vitamins.

You must order Medications not available from FDB Canada as an ***Other*** medication. Two ***Other*** categories you can use are:

- **Other, Medication**.
- **Vitamin, Other** for vitamins.

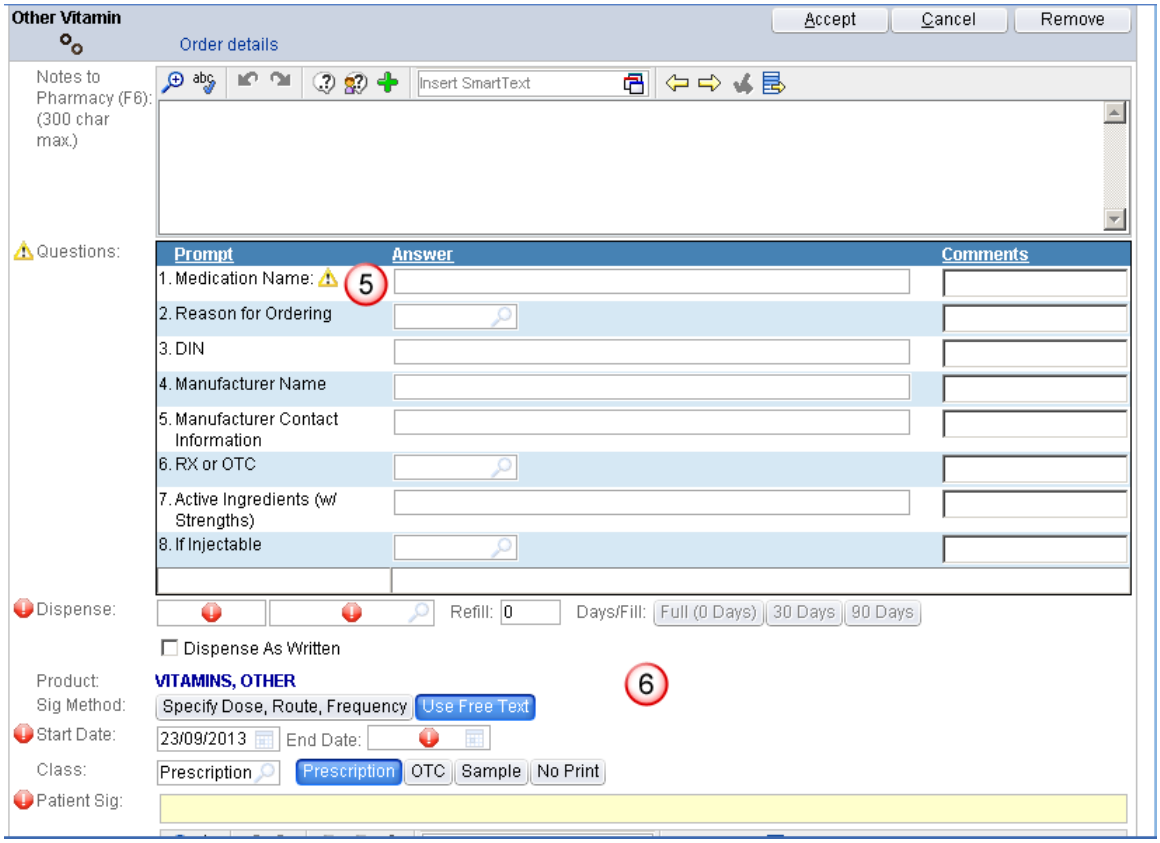
Medications entered as an ***Other*** category are essentially free text entries. As a result, interaction checking with charted medications or allergies, and duplicate order checking do not take these entries into account. Free text entries also have limited value in terms of reportability.

Because a new FDB source file is uploaded to ***e*CLINICIAN - EMR** weekly, you need to do periodic checks to see if any previously ***missing*** items, that were charted as an ***Other***, are now available.

The next topic ***Custom-Built Medications & Vitamins*** describes how you can manage medications and vitamins documented as ***Other***.

To enter a medication or vitamin not available from FDB Canada:

1. From the navigator table of contents, access the Meds & Orders section.
2. In the **Search for new order** field, use completion matching to search for ***Other Medication*** or ***Vitamins, Other***. The Database Search window appears.
3. Select the appropriate record.
4. Click **Accept**. The Order Composer displays.
5. In the **Medication Name** field, type the name of the medication. This name rather than ***Other Medication*** or ***Other, Vitamin*** displays in the patient's medication lists.
6. Complete the remaining order details as required.



7. When you are finished, click **Accept**. The Order Composer closes.
8. Review the sig details in the Summary Sentence.
9. Sign or pend your order(s). When signing orders, a Medication Warnings window displays because the system cannot perform dose checking for you. You must confirm the dose manually.

CUSTOM-BUILT MEDICATIONS & VITAMINS

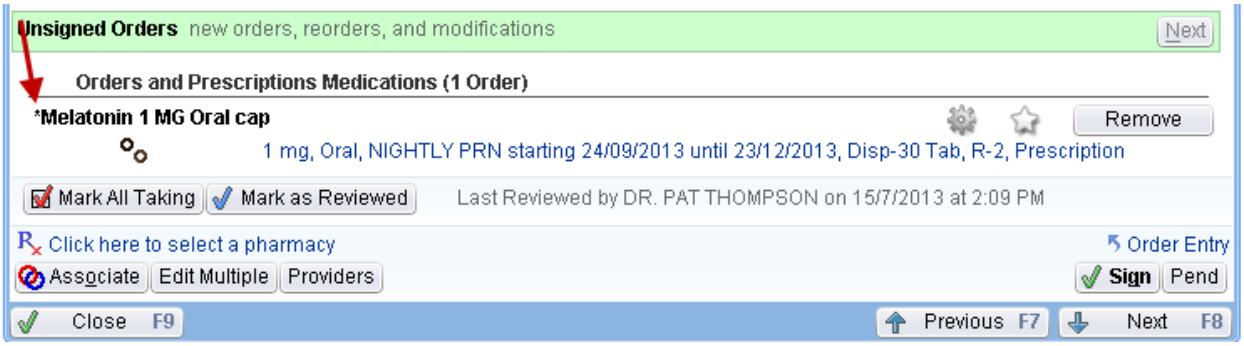
Every quarter the ***e*CLINICIAN** team and the Pharmacy team perform an analysis of the medications and vitamins entered as ***Other***.

The following criteria form the basis for selecting items to be built as a custom medication or vitamin:

- New drugs on the market that are not yet available from FDB (First Data Bank Canada),
- Commonly used medications that are not (or may never be) available from FDB (includes certain vitamins), and
- Clinical trial medications.

When medications or vitamins are custom-built, if a proxy medication exists, it is used so that Drug to Drug and Drug to Allergy interactions are available.

Custom-built medications that do not have a proxy, are created with an asterisk beside the medication made. This visual indicator means that there is no interaction checking when you sign these orders.



When custom-built medications and vitamins are added to ***e*CLINICIAN**, you receive an In Basket message. The following actions may then be required:

- If the custom-build medication/vitamin replaces one currently on your personal preference list, you need to delete the item from your list. For details on these steps, refer to the topic ***Remove an Item from your Personal Preference List***.
- If appropriate, add the custom built medication to your personal preference list. For details on these steps, refer to the topic ***Add an Order to your Personal Preference List***.
- If a proxy medication was not available for the newly built medication/vitamin, when placing future orders, you need to manually check interactions, as described in the previous topic.

ORDER MEDICATIONS WITH COMPLEX DOSING

Some prescriptions involve sigs that are too complex to order discretely, in this case, you have to enter the instructions as free text.

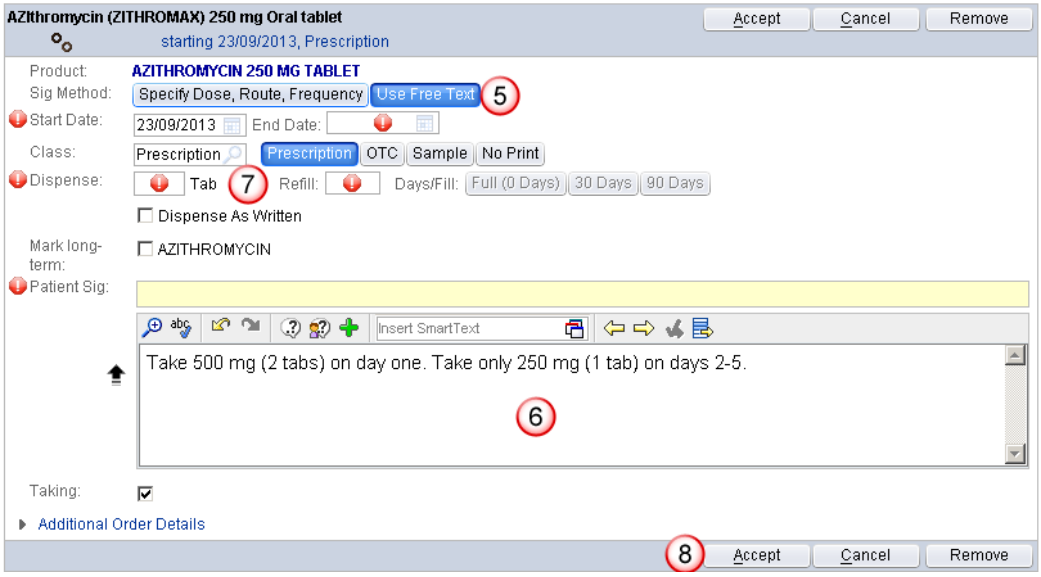
There are three common reasons you would use free text:

- There isn't a specific dose for the prescription, which is often the case for topical creams and ointments.
- The patient needs to take different doses at different times of the day. For example, s/he takes two tablets in the morning and one in the evening.
- The patient needs to take different doses on different days. For example, you might taper a patient off of a medication (demonstrated below).

To order a medication with complex dosing:

1. From the navigator table of contents, access the Meds & Orders section.
2. In the **Search for new order** field, use completion matching to search for the medication. A search window displays with a list of records matching your search.
3. Select the appropriate order.
4. Click **Accept**. The Order Composer displays with some fields pre-populated.

5. Click **Use Free Text**. The Order Composer displays with fewer and different fields, including a **Patient Sig** field where you can enter free text.
6. In the **Patient Sig** field, type the instructions.
7. Complete the remaining details as required.
8. Click **Accept**.



The Order Composer closes.

9. Review the sig details in the Summary Sentence.

Add Medications with Complex Dosing to Personal Preference List

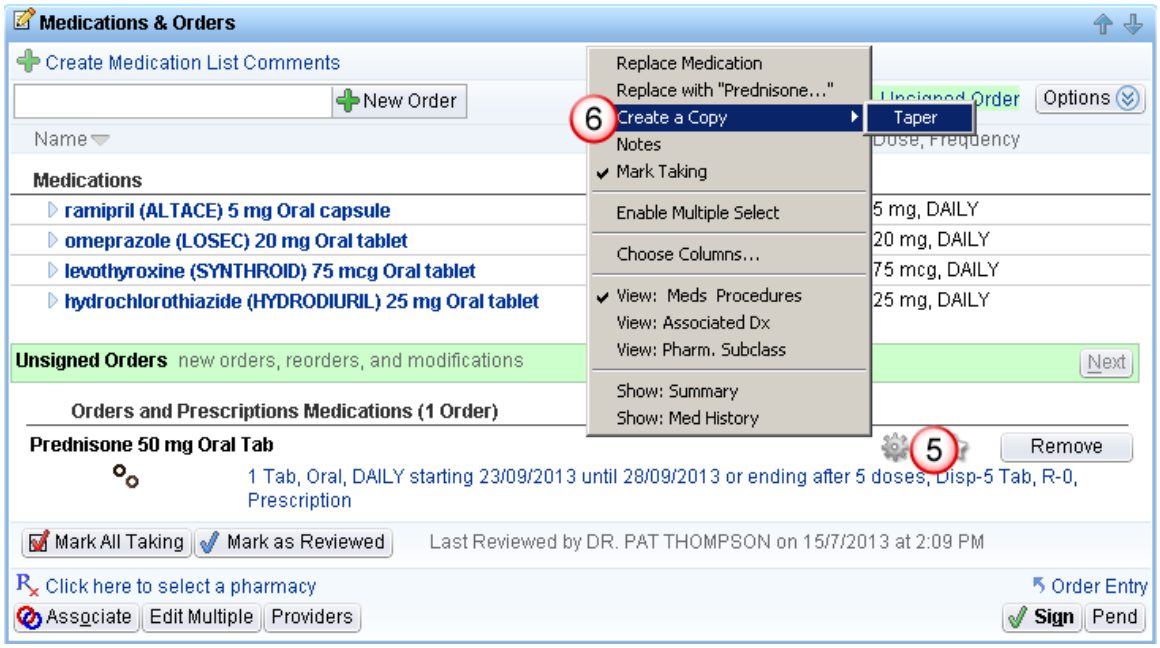
If this is a medication you prescribe regularly, and with the same sig, consider adding this to your personal preference list. To learn more about this, refer to the topic **Save a Medication Order to your Personal Preference List During an Encounter**.

10. Sign or pend your order(s).

TAPERING MEDICATIONS

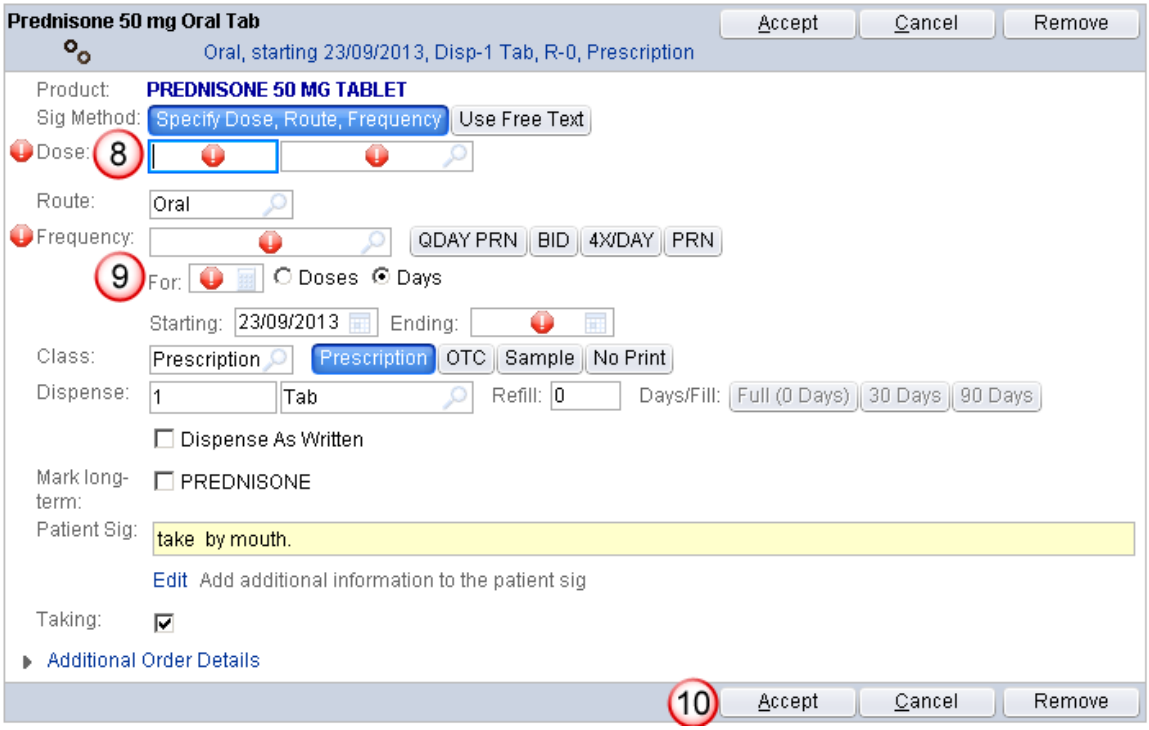
To taper medications in ***e*CLINICIAN**, you can create multiple similar prescriptions simultaneously with gradually increasing or decreasing doses.

1. From the navigator table of contents, access the Meds & Orders section.
2. In the **Search for new order** field, use completion matching to search for the medication. A search window displays with a list of records matching your search.
3. Select the appropriate order.
4. Click **Accept**. The order displays as an Unsigned Order.
5. To the right of the medication name, click the gear icon. An order related action menu displays.
6. From the menu, select **Create a Copy > Taper**.



A duplicate order appears as an Unsigned Order with a stop sign beside it.

7. Click the medication hyperlink to launch the order composer.
8. Enter the tapered dose information.
9. Enter the frequency information. The remaining mandatory fields auto-populate.
10. Click **Accept**.

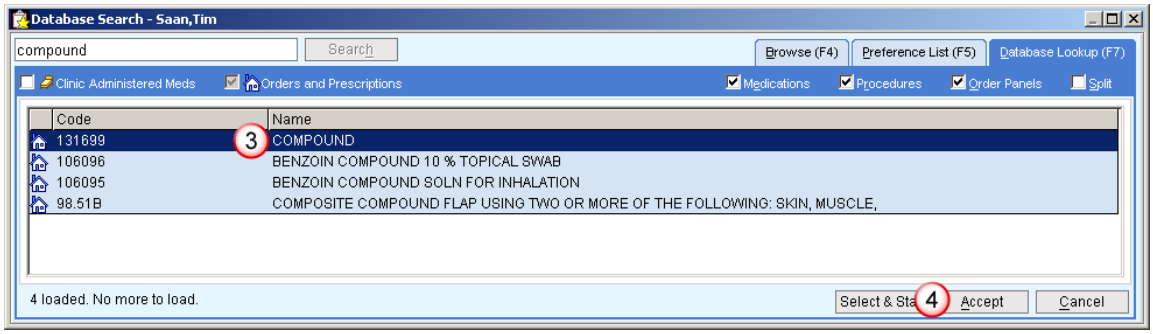


The unsigned order redisplays.

11. Repeat steps 5-10 for to taper the medication further.
12. When you are done, sign or pend your order(s).

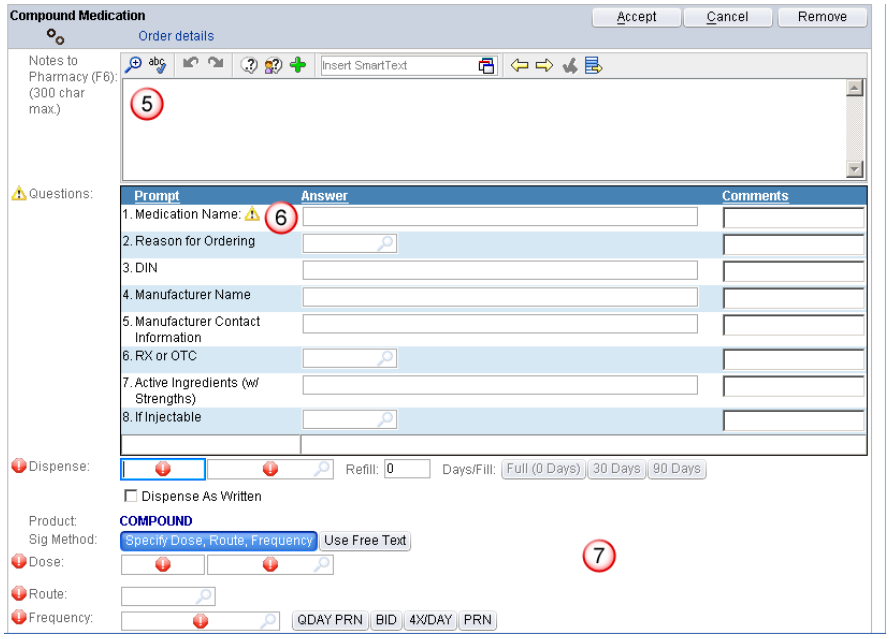
ORDER A COMPOUND MEDICATION

1. From the navigator table of contents, access the Meds & Orders section.
2. In the **Search for new order** field, completion match on ***compound***. The Database Search window displays records matching your search.
3. Select the record that displays as ***COMPOUND***.
4. Click **Accept**.



The Order Composer displays.

5. In the **Notes to Pharmacy** field, enter all of the information regarding the ingredients for the compound. This is the area that prints on the prescription as instructions for the pharmacy.
6. In the **Medication Name** field, type the name of the compound. This name rather than ***Compound*** then displays in the patient's medication lists.
7. Complete the remaining order details as required.



8. Click **Accept**. The Order Composer closes.
9. Review the sig details in the Summary Sentence.

Add Compounds to Personal Preference List

Before you sign your order, click the **star** icon to the right of the compound name. This action saves the medication along with the newly entered details to your personal preference list. With a few clicks the compound can be quickly ordered for another patient.

For details on these steps, refer to the topic **Save a Medication Order to your Personal Preference List During an Encounter**.

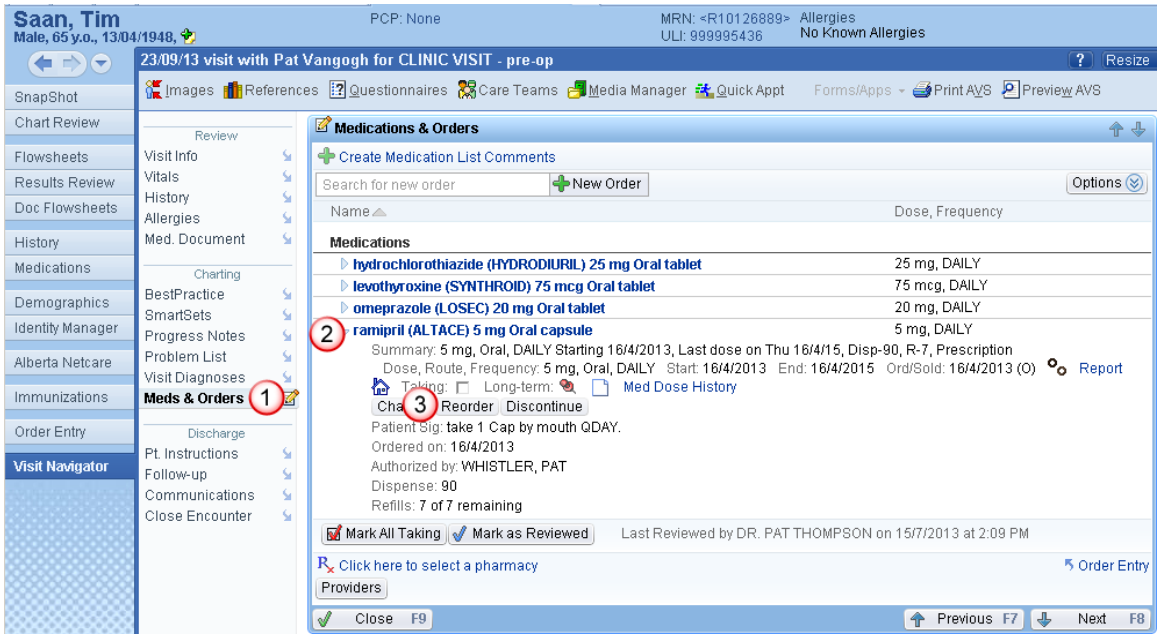
10. Sign or pend your order(s).

REORDER A MEDICATION

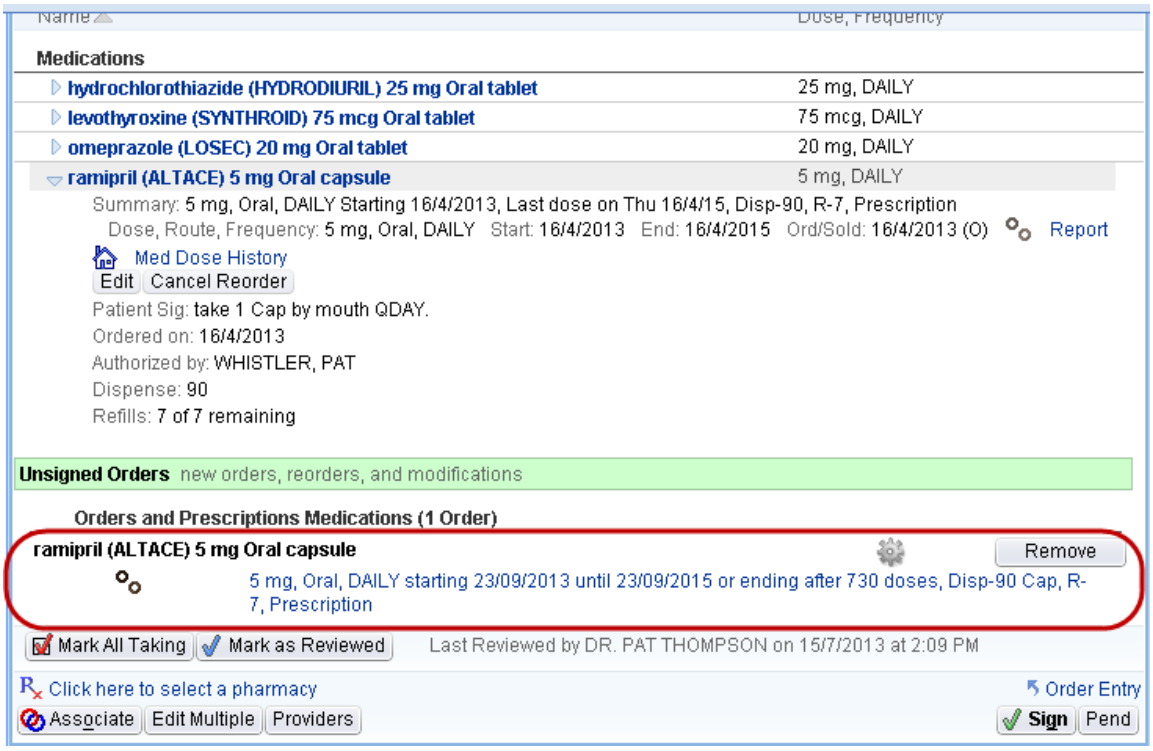
You can reorder medications from the Meds & Orders section of navigators. This workflow involves reordering the medication using the patient's most recent medication details.

1. From the navigator table of contents, access the Meds & Orders section.
2. Under the Medications heading, click the medication order hyperlink. The details of the medication display.
3. Click **Reorder**.

TIP 1:Refer to the **Change Appearance of the Medications and Orders** section to learn how you can personalize this navigator section to make these buttons more accessible.



The reordered medication displays in the Unsigned Orders subsection.


Name
Dose, Frequency
Medications
hydrochlorothiazide (HYDRODIURIL) 25 mg Oral tablet
25 mg, DAILY
levothyroxine (SYNTHROID) 75 mcg Oral tablet
75 mcg, DAILY
omeprazole (LOSEC) 20 mg Oral tablet
20 mg, DAILY
ramipril (ALTACE) 5 mg Oral capsule
5 mg, DAILY
Summary: 5 mg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription
Dose, Route, Frequency: 5 mg, Oral, DAILY Start: 16/4/2013 End: 16/4/2015 Ord/Sold: 16/4/2013 (O)
Report
Med Dose History
Edit
Cancel Reorder
Patient Sig: take 1 Cap by mouth QDAY.
Ordered on: 16/4/2013
Authorized by: WHISTLER, PAT
Dispense: 90
Refills: 7 of 7 remaining
Unsigned Orders new orders, reorders, and modifications
Orders and Prescriptions Medications (1 Order)
ramipril (ALTACE) 5 mg Oral capsule
Remove
5 mg, Oral, DAILY starting 23/09/2013 until 23/09/2015 or ending after 730 doses, Disp-90 Cap, R-7, Prescription
Mark All Taking
Mark as Reviewed
Last Reviewed by DR. PAT THOMPSON on 15/7/2013 at 2:09 PM
Click here to select a pharmacy
Order Entry
Associate
Edit Multiple
Providers
Sign
Pend

4. Review the Summary Sentence. If you wish to modify the sig, click the Summary Sentence to launch the Order Composer. If not, proceed to step 6.
5. Update order details as required and click **Accept**. The Order Composer closes.
6. Sign or pend your order(s).

Best Practice – Reorder Medications

When a patient requires a refill, reordering the medication using the corresponding Reorder button causes the original order (Rx) to be automatically discontinued. This avoids the creation of duplicate or overlapping medication records.

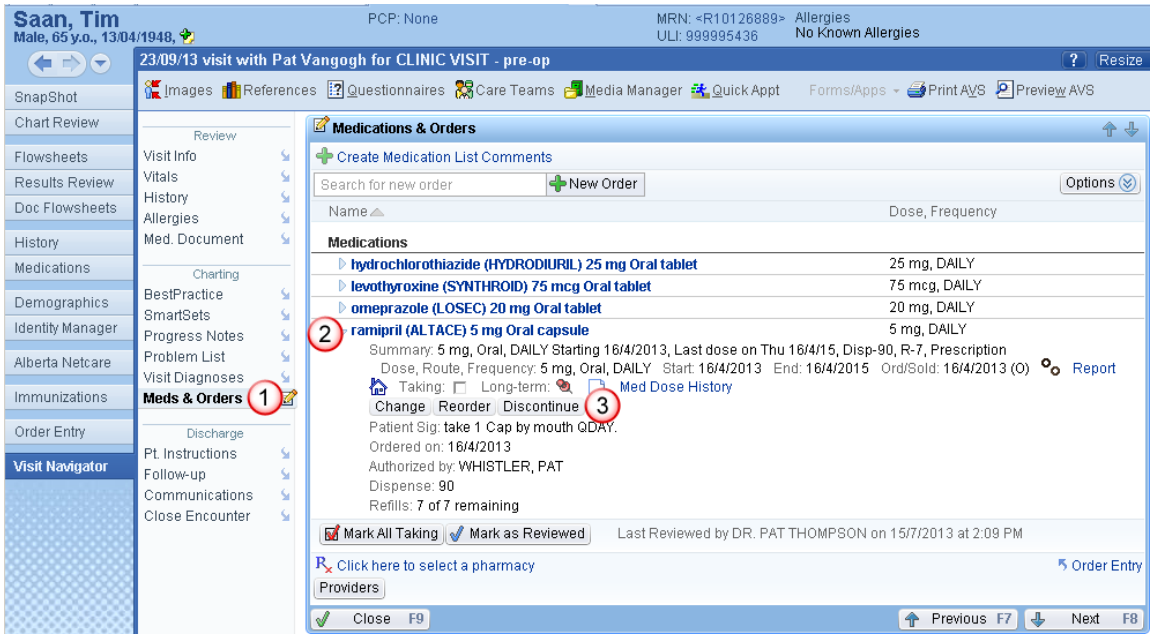
DISCONTINUE A MEDICATION

The Medications area of the Meds & Orders navigator section lists the medications the patient is currently taking. These may be medications that were prescribed in ***e*CLINICIAN** or were patient-reported medications prescribed elsewhere.

If you wish to cancel a prescribed medication or indicate that a patient is no longer taking a medication, you accomplish both in the Meds & Orders navigator section.

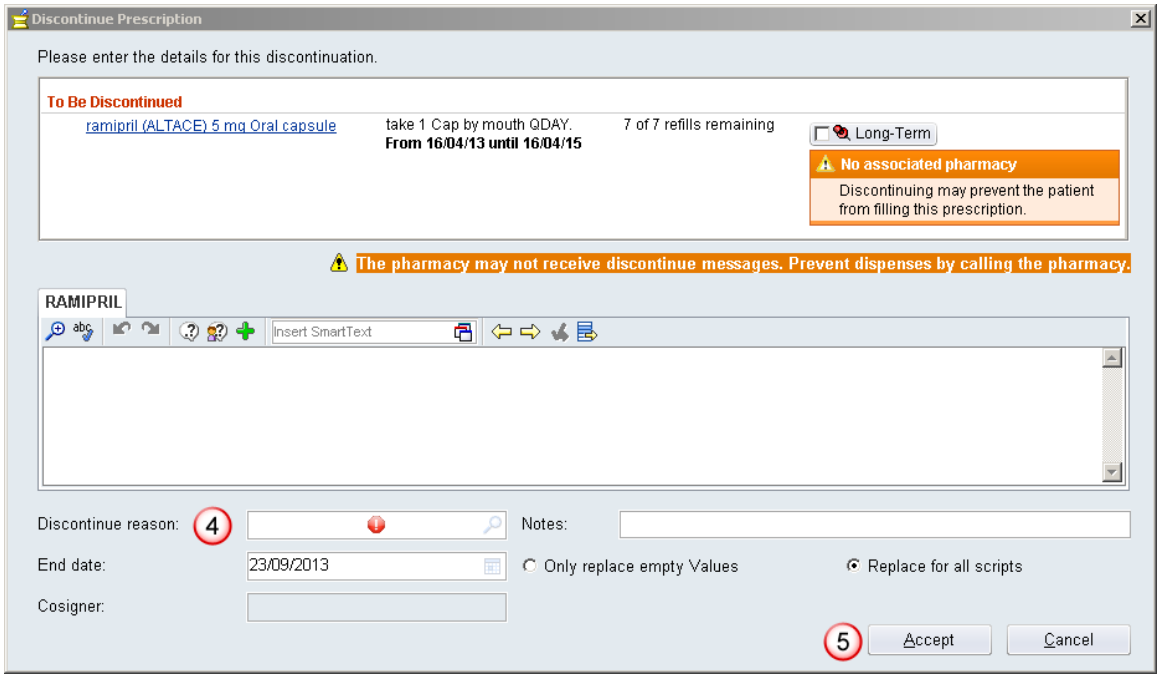
1. From the navigator table of contents, access the Meds & Orders section.
2. Under the Medications heading, click the medication order hyperlink. The details of the medication display.
3. Click **Discontinue**.

TIP 1:Refer to the **Change the Appearance of the Medications & Orders** Section section to learn how to make these buttons more accessible.



The Discontinue Prescription window displays.

4. In the **Discontinue reason** field, either use completion matching or click the **Selection tool** (magnifying glass) to add an appropriate reason.
5. Click **Accept**. The Meds & Orders section redisplays.



TIP 2: You can also use these steps to cancel a medication that you ordered in error and discovered immediately after signing the order.

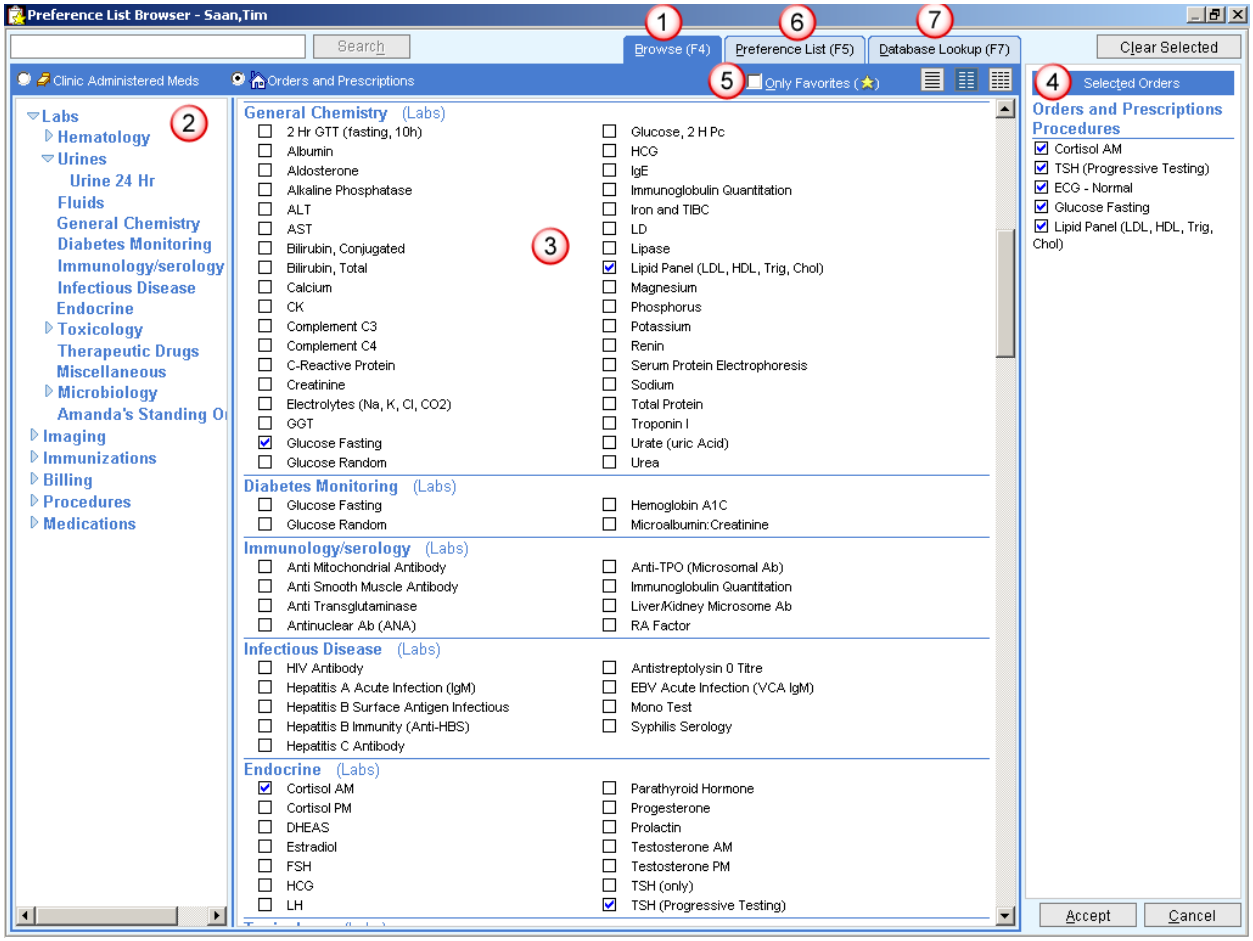
USE ORDER PREFERENCE LISTS DURING AN ENCOUNTER

Preference Lists are a great way to help you quickly place orders for medications and procedures that you most commonly use.

There are two types of preference lists:

- System preference lists are built by the ***e*CLINICIAN** project team to reflect ordering practices for a defined group of users such as for your specialty.
- Personal preference lists are built by individual users. You can add orders to your personal preference lists so that they reflect your unique ordering practices.

You can access these preference lists clicking the New Order button in the Meds & Orders navigator section. The window that displays has several distinct areas with which you should become familiar.



① **BROWSE TAB**: This is where you can access the Preference List Browser which resembles a paper requisition form. It contains the order types and sub-types contained within your personal preference list and the system preference list. It comprises three panes: the left-hand pane, middle pane, and Selected Orders pane.

② **PREFERENCE LIST BROWSER LEFT-HAND PANE**: Lists the order types and sub-types you can order. Each heading is also a hyperlink that takes you to the respective section in the middle pane.

③ **PREFERENCE LIST BROWSER MIDDLE PANE**: Displays the individual orders which you select by clicking the checkboxes to the left of the order name.

④ **PREFERENCE LIST BROWSER SELECTED ORDERS (RIGHT-HAND) PANE**: Displays the orders you selected from the Preference List browser middle pane.

⑤ **ONLY FAVORITES CHECKBOX**: This is a filter which, when selected, displays only those orders on your personal preference list.

⑥ **PREFERENCE LIST TAB**: This is where you can search the system preference lists for orders, using completion matching. There are filters for refining your search to Medications, Procedures, and/or Order Panels.

⑦ **DATABASE LOOKUP TAB**: This is where you can search the entire list of orders contained within the system, regardless of specialty. There are filters for refining your search to Medications, Procedures, and/or Order Panels.

SAVE A LAB ORDER TO YOUR PERSONAL PREFERENCE LIST DURING AN ENCOUNTER

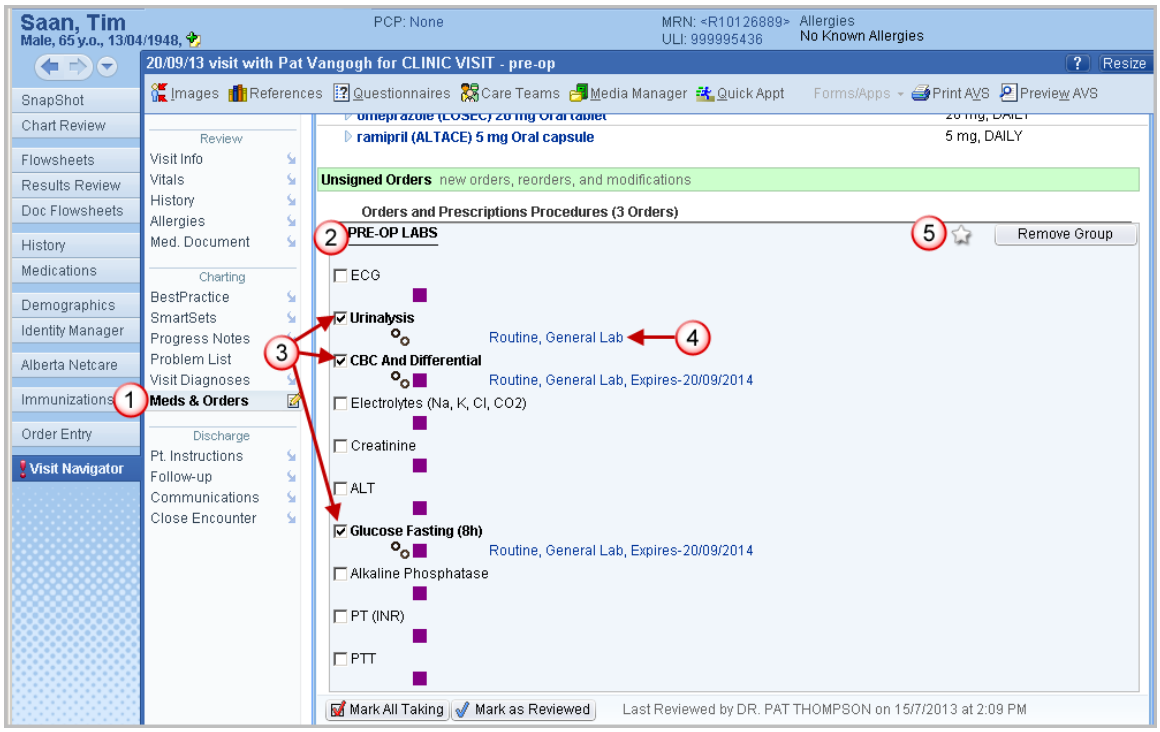
During an encounter you can add orders to your personal preference list. To demonstrate, the steps below involve adding a pre-op lab panel to your personal preference list.

You can personalize specialized lab panels built for your specialty. For example, the specialty-built lab panel may contain more tests than you typically order. You can make your selections from the lab panel and then save these selections as a personal preference.

1. From the navigator, access the Meds & Orders section.
2. Place an order for a panel. The order displays under the Unsigned Orders section.

Notice that panels are built without any of the tests pre-selected. You have to manually select them.

3. Click on the test names to build a subset of panel tests. The selections display with a checkmark to the left and a Summary Sentence to the right.
4. If you wish to add/change details of the order, click the Summary Sentence to launch the Order Composer and proceed to make the necessary changes.
5. To add the panel with the pre-selected values to your personal preference list, to the right of the panel order, click the **Add order to preference list** button (white star). The Add to Preference List window displays.



6. In the **Display name** field, type a meaningful or shortened version of the order's name.

Notice that the system has a pre-populated section called, ***Existing***. By default the system adds your personal preference list order to this section unless you create a new section. To create a new section to group orders of this kind:

7. Click **New Section**. The New Section window displays.
8. In the **Display name** field, type the section name. This could be a sub-category name or anything that sets the list apart, such as ***My Panels***.
9. In the **Sort alphabetically in order entry** field, type ***y*** (for yes).
10. Click **Accept**. The Add to Preference List window redisplays.
11. Update any order-specific details as required by clicking on the Summary Sentences.
12. When you are done, click **Accept**.

The order is now saved to your Preference List. Also, a Replace Order pop-up window displays.

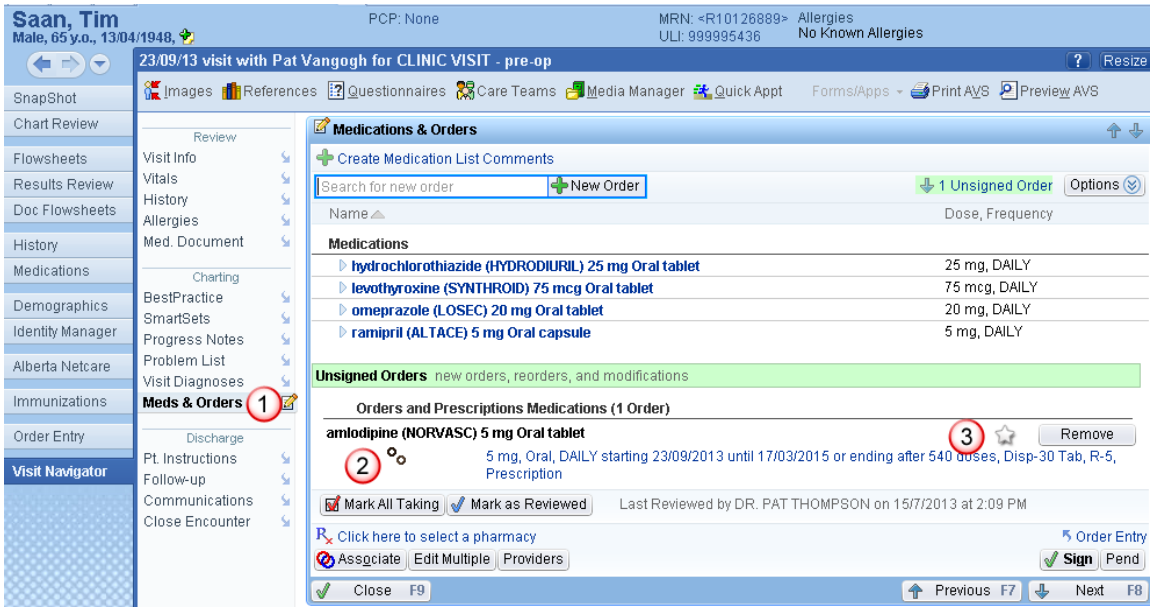
13. If you made changes to your original sig order in the Add to Preference List window, and you want to replace it with the order from your personal preference list, click **Replace Order**. To keep your original order, click **Keep Order**.

TIP: During an encounter you can add orders to your personal preference list up until you sign your order. Once you sign the order, the star icon no longer displays.

SAVE A MEDICATION ORDER TO YOUR PERSONAL PREFERENCE LIST DURING AN ENCOUNTER

During an encounter you can add medication orders to your personal preference list.

1. From the navigator, access the Meds & Orders section.
2. Place an order for a medication and complete the details of the patient sig.
3. To the right of the medication, click the **Add order to preference list** button (white star).



The Add to Preference List window displays.

4. In the **Display name** field, type a meaningful or shortened version of the order's name.

Notice that the system has a pre-populated section called, ***Existing***. By default the system adds your personal preference list order to this section unless you create a new section. To create a new section to group orders of this kind:

5. Click **New Section**. The New Section window displays.
6. In the **Display name** field, type the section name. This could be a sub-category name or anything that sets the list apart, such as ***My Meds***.
7. In the **Sort alphabetically in order entry** field, type ***y*** (for yes).
8. Click **Accept**. The Add to Preference List window redisplays.

Notice that the system pulls in ***most*** of the information you specified in your order. The Starting and Ending dates as well as any free text information you added to the patient sig are not carried over from the original order.

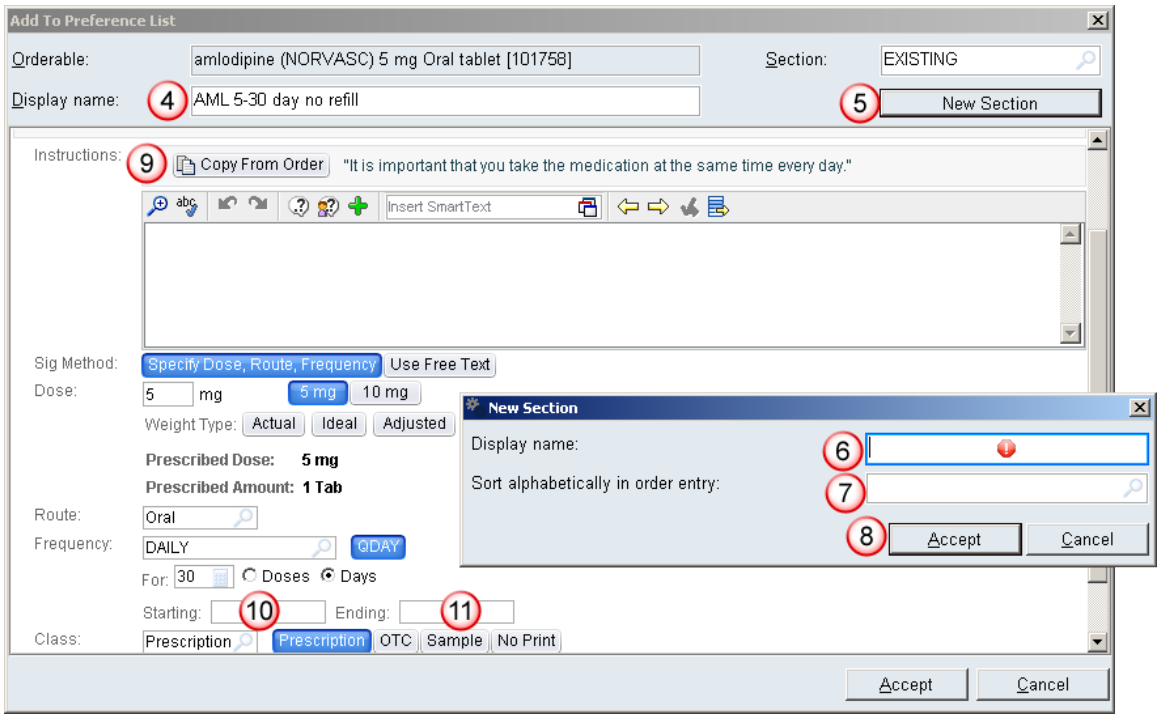
9. To pull in your patient instructions, in the Instructions area, click **Copy From Order**.
10. In the **Starting** date field, type ***s***.

TIP 1: Once you've entered a Starting date, the Ending date should auto-calculate so long as you entered information in the **For** field in the Frequency area. If the Ending date has not auto-calculated, either complete the **For** field, or proceed to step 11.

11. In the **Ending** date field, type ***s*** **+** ***<duration of the therapy in days>***. The **For** field auto-calculates.

TIP 2: The **s** in this formula stands for the starting date. For example, for a one month supply of a particular medication, type **s+30**. For a long term medication, type **s+365**.The start and end date pre-populate each time you place the order from your personal preference list.

TIP 3: The Add to Preference List window is the only place where you can use this formula.



12. Update the remaining fields, as required.

13. When you are done, click **Accept**. The order is now saved to your Preference List. Also, a Replace Order pop-up window displays.

14. If you made changes to your original sig in the Add to Preference List window, and you want to replace it with the order from your preference list, click **Replace Order**. To keep your original order, click **Keep Order**.

TIP 4: During an encounter you can add orders to your personal preference list up until you sign your order. Once you sign the order, the star icon no longer displays.

15. Click **Accept**. The order is now saved to your Preference List.

ENTER ORDERS USING A PERSONAL PREFERENCE LIST

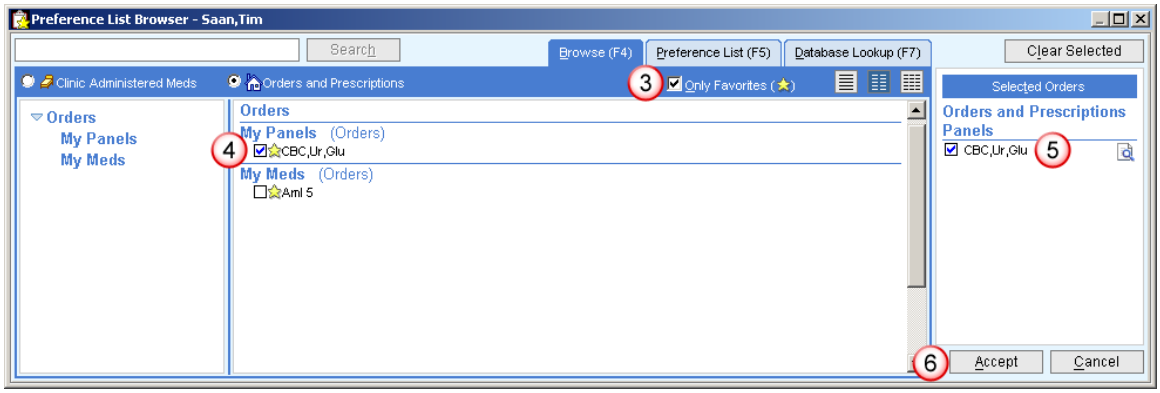
1. From the navigator, access the Meds & Orders section.
2. Click **New Order**. The Preference List Browser displays.
3. To quickly locate items on your personal preference list, select the Only Favorites checkbox. In the middle pane, below the Orders heading, a list of your preference orders displays.

   TIP 1: You can also view your personal preference list by using the left-hand pane of the Preference List Browser window. From here, click the blue arrow beside the Orders heading to expand the menu. Then, click one of your newly created sections to view the personalized orders.

4. In the middle pane, select the appropriate order(s).

   TIP 2: You can place other orders while you have the Preference List Browser open. Deselect Only Favorites to see the full Browser, or go to the other tabs and use the **Search** field for completion matching.

5. In the Selected Orders pane, review your orders.
6. When you are done, click **Accept**.

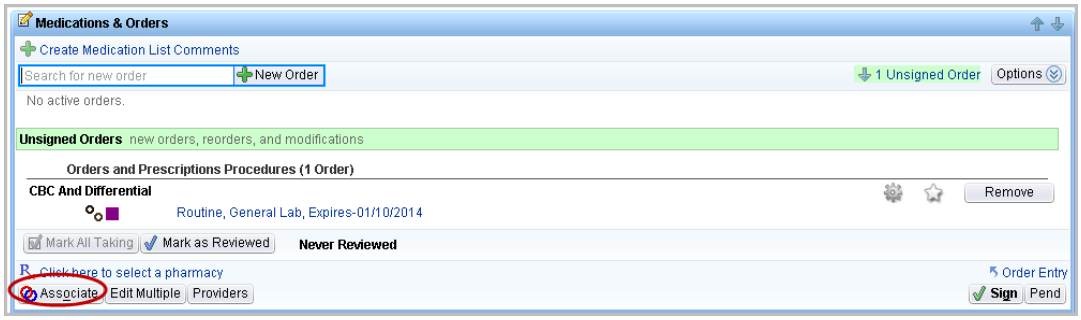


7. Sign or pend your order(s).

ASSOCIATE ORDERS WITH DIAGNOSIS

The association of orders to diagnoses is not a system-wide requirement and depends on your security role. You may however, encounter specific workflows where this is a required or optional task. The association of a billing code to the diagnoses and the association of a ***referral to anticoagulation monitoring (order)*** to the diagnoses are both examples of workflows where you ***must*** perform this association.

1. Place your orders but do not sign or pend them.
2. Under the Unsigned Orders heading, in the bottom left corner, click **Associate**.

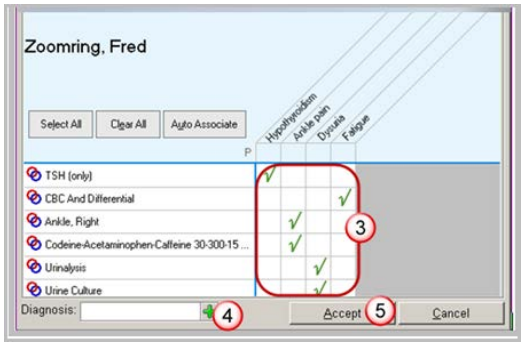


The Order -- Associate Diagnoses window displays. Here you will indicate the relationship between diagnosis and the order(s).

3. To the right of the desired order, click the column corresponding to appropriate diagnosis.

   A checkmark displays beside the order in the column. The interlocking red and blue rings also display beside the order indicating that the order is associated with a diagnosis.

4. A diagnosis can be added to the chart using the **Diagnosis** field.
5. When you are finished, click **Accept**.



SIGN YOUR ORDERS

Orders must be signed. Depending on your security level you will sign the order directly or sign the order as a delegate.

Several things happen when you sign your orders including the following:

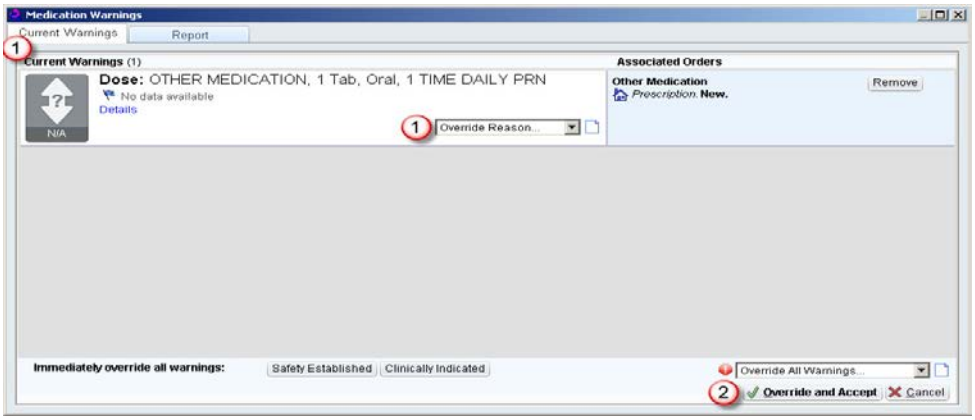
- Drug to Drug and Drug to Allergy interactions are checked.
- Orders are checked for duplicates in the last 14 days.
- Lab and Diagnostic Imaging tests – Requisitions print to the designated printer.
- Medications – Prescriptions print to the designated printer.
- In Clinic procedures – Drops to the Procedure Orders section of the navigator so procedure can be documented.
- Requests for Service – Goes to the Schedulable Orders work list so that clinical staff can schedule their own appointments.
- Outpatient Referral Services – Prints an Outpatient Rx form (may not meet the need for the service being referred to/requested so paper form may been to be filled out).
- Referrals to a Specialty – If the 'referred to' clinic is using ***e*CLINICIAN**, the referral will fall onto their referral list. If the 'referred to' clinic is not using ***e*CLINICIAN**, then you will follow your current manual processes. Your administrative staff will also manually track the referral using a series of ***e*CLINICIAN** Referral reports.
- Billing codes – Sent to ***e*CLINICIAN-Billing**.

WARNING MESSAGES

1. In the current warning area, from the Override Reason menu, make a selection.

   TIP: If there multiple warnings, on the bottom left of the window, there are **Immediately override all warnings** buttons. Clicking these buttons automatically closes the Medications Warnings window.

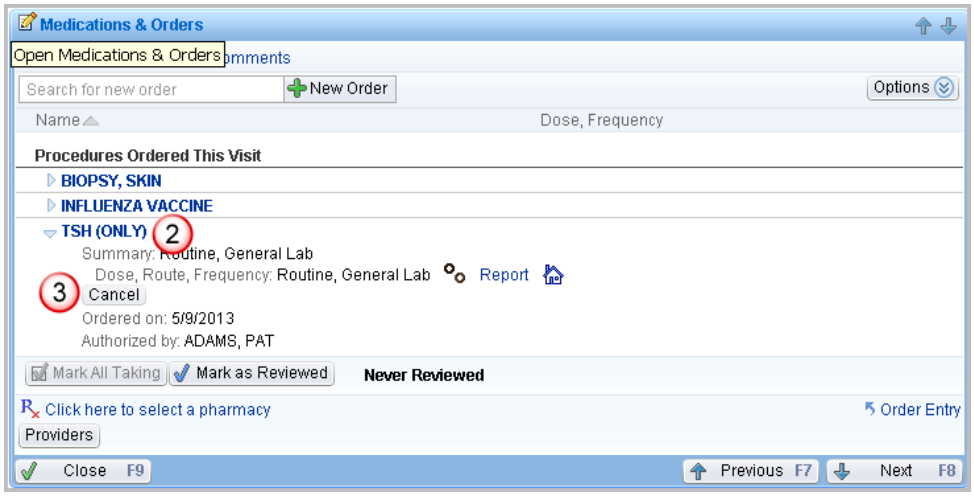
2. Click **Override and Accept**.



CANCEL A SIGNED ORDER

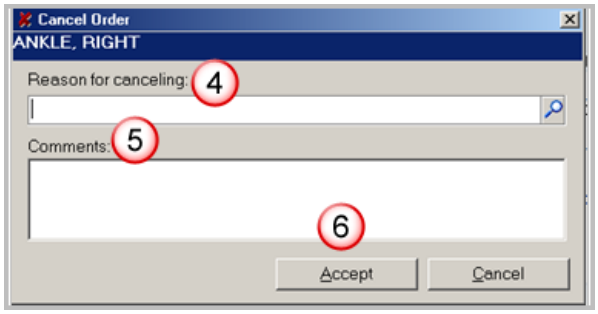
You can cancel an order as long as the order has not yet been resulted. If, after signing an order you discover that you need to cancel it, perform these steps:

1. From the Visit Navigator table of contents, access the Meds & Orders section.
2. Next to your order, click the summary sentence hyperlink. The Order Composer displays.
3. Click **Cancel**.



The Cancel Order window displays.

4. In the **Reason for cancelling** field, use completion matching or the **Selection** Tool to enter an appropriate reason.
5. If appropriate, type a comment.
6. When you are done, click **Accept**.



REPRINT REQUISITIONS AND PRESCRIPTIONS WITHIN eCLINICIAN

Occasions may arise where you need to reprint requisitions and/or prescriptions. There are two different ways to reprint in ***e*CLINICIAN**:

- The Order Review activity
- Order Entry activity

EVALUATE THE REPRINTING OPTIONS

The Order Review activity is recommended for reprinting orders when the following conditions apply:

- The order(s) you want to reprint **successfully printed the first time**; ***i.e***. there weren't mapping/connection issues between the printer and workstation.
- The order(s) was placed within 60 days of the current date.
- You don't mind that each order prints on a separate page.

If your situation does not meet these conditions, you can cancel the original order(s) in the Order Entry activity, and then reorder them within the original encounter.

The table below summarizes these two solutions:

		Order Review	Order Entry (Cancel Order) & Reorder
Original order printed?	Yes	✓	
	No		✓
# of days order was signed prior to the current date	≤ 60 days	✓	
	> 60 days		✓
Will print multiple orders on the same piece of paper?	Yes		✓
	No	✓	

Regardless of which option you choose, you must first open the encounter for the original order.

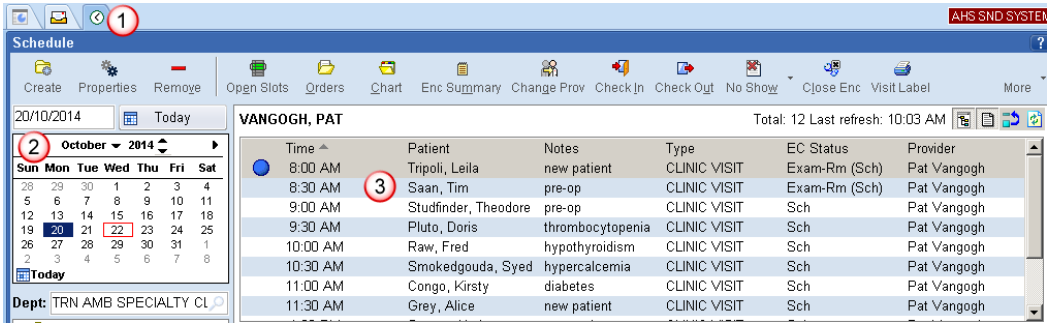
OPEN THE ORIGINAL ENCOUNTER

You can open an encounter using one of the following two ways:

- Multi-Provider Schedule to find the patient appointment
- Epic button to look up the patient and the open or closed encounter

USE THE MULTI-PROVIDER SCHEDULE

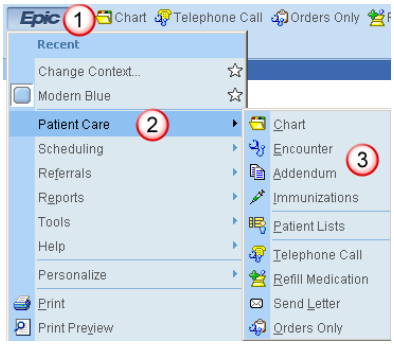
1. Access the Schedule activity.
2. Use the calendar to navigate to the appropriate date.
3. Locate the patient's appointment.



4. To open the encounter, **double-click** the appointment row. If the encounter has been closed, create an addendum.

USE THE EPIC BUTTON

If you do not know the date of the scheduled encounter, or you are searching for an unscheduled encounter such as a Medication Refill or Orders Only, you can search from the Epic Menu.



1. Click the **Epic** button.
2. Select Patient Care.
3. To search for an open encounter, select Encounter.
4. Type the patient's last name, first name, and date of birth in the corresponding fields.
5. Click **Find Patient**.
6. Click the appropriate patient and then click **Accept**. Encounters that have been ***closed*** do not display here.
7. If you do not see the applicable encounter in this list, click **Cancel** and complete steps 9 through 11 below, otherwise continue with step 8.
8. From the Encounter Selection window, select and open the appropriate encounter.
9. To search for a Closed Encounter, click the **Epic** button.
10. Select Patient Care.
11. Select Addendum.

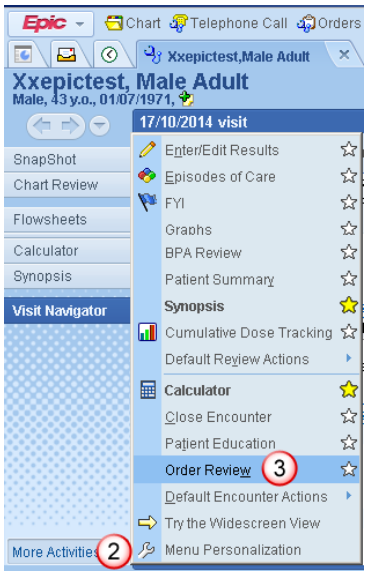
To reprint via the Order Review Activity, proceed to the next section ***Reprint Using the Order Review Activity***.

To learn about cancelling orders and reordering, refer to the section ***Reprint Using the Order Entry Activity***.

REPRINT USING THE ORDER REVIEW ACTIVITY – RECOMMENDED

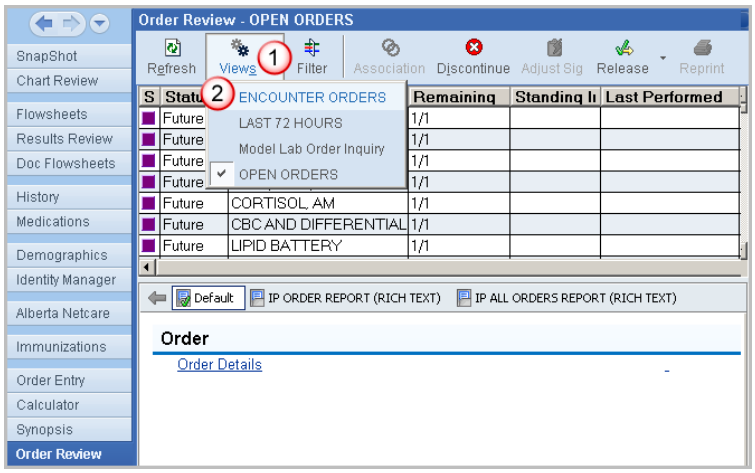
The Order Review activity allows users to look up previous orders and reprint both requisitions and prescriptions. To access the Order Review activity:

1. Find and open the encounter in which the original orders were signed. If the encounter was previously closed, create an Addendum.
2. From the bottom of the Activity tab list, click **More Activities**.
3. From the menu, select Order Review.



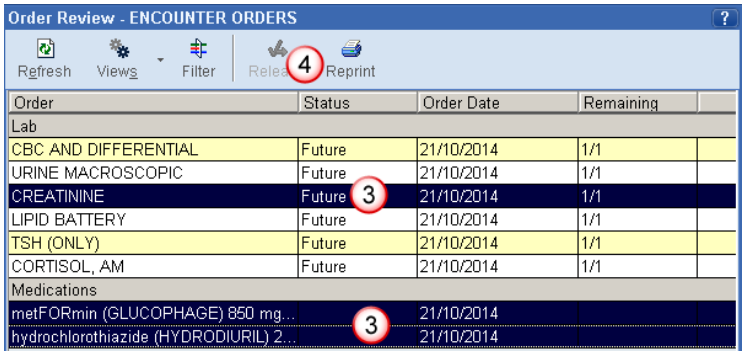
To view the orders which were placed during the encounter:

1. From the Activity toolbar, click **Views**.
2. Select the Encounter Orders option.

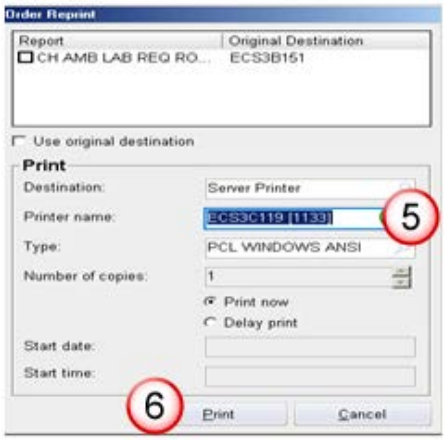


The orders are grouped into Labs, Medications, etc.

3. Click the orders you wish to reprint. To select multiple orders, hold the **Ctrl** key while you click the desired orders.
4. After you have selected your orders, from the activity toolbar, click **Reprint**.



5. Verify that the printer listed in the **Printer name** field is correct. If not, click the Selection tool to view a list of possible printers and choose the appropriate one.
6. After you select a printer, click **Print**.



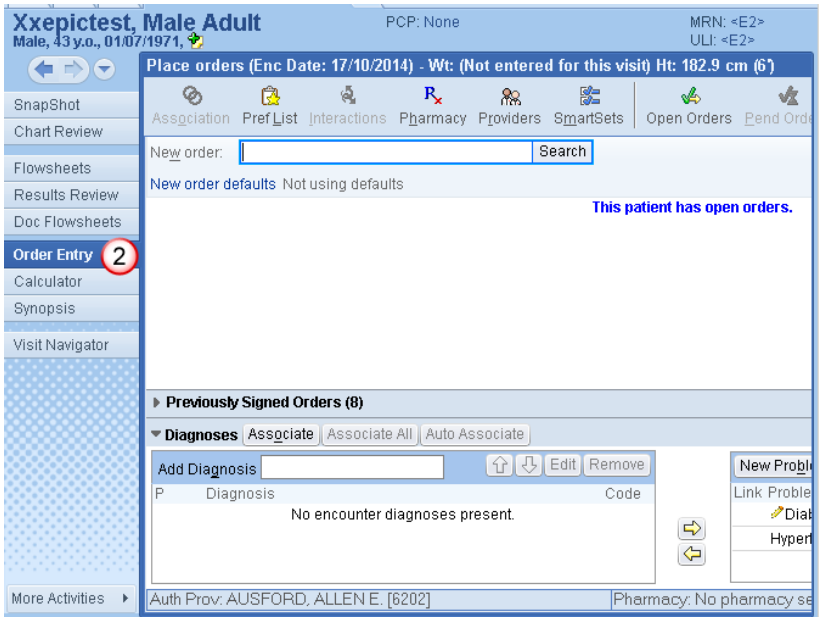
7. When you are finished, exit the patient workspace or sign the Addendum, if appropriate.

PRINT USING THE ORDER ENTRY ACTIVITY

For situations in which Order Review won't work, rather than reprinting the original orders, you can cancel/discontinue them and reorder them within the original encounter.

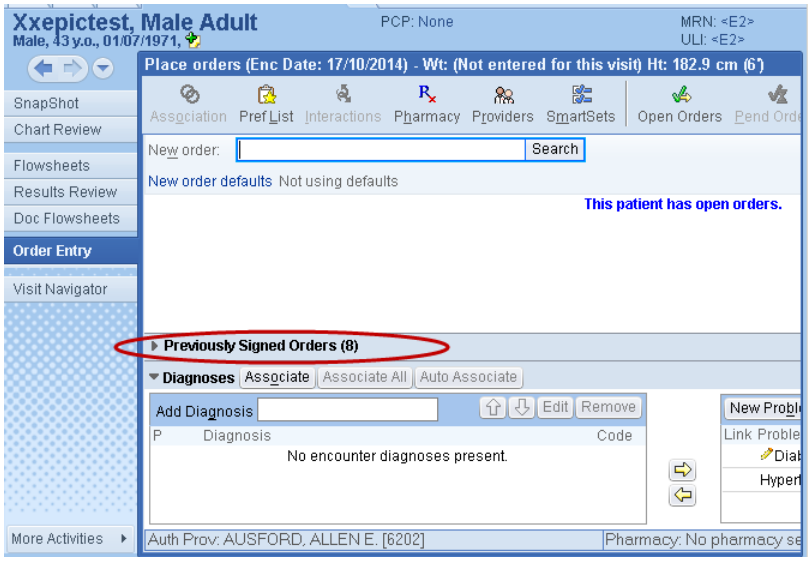
The Order Entry activity allows you to cancel orders. To access the Order Entry activity:

1. Find and open the encounter in which the original orders were signed. If the encounter is closed, create an Addendum.
2. From the Activity tab list, select Order Entry.

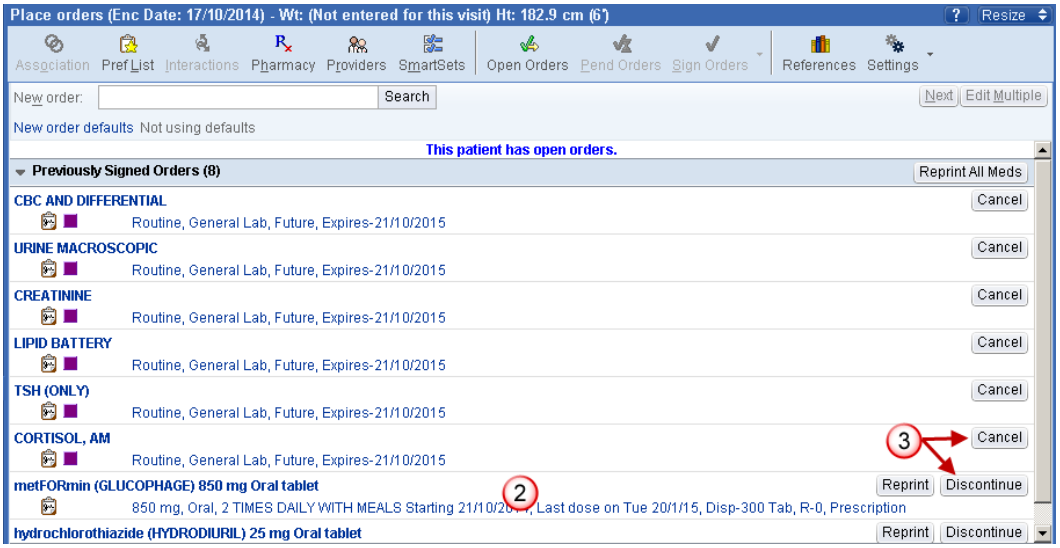


To cancel/discontinue orders and reorder:

1. Expand the Previously Signed Orders section by clicking the heading.

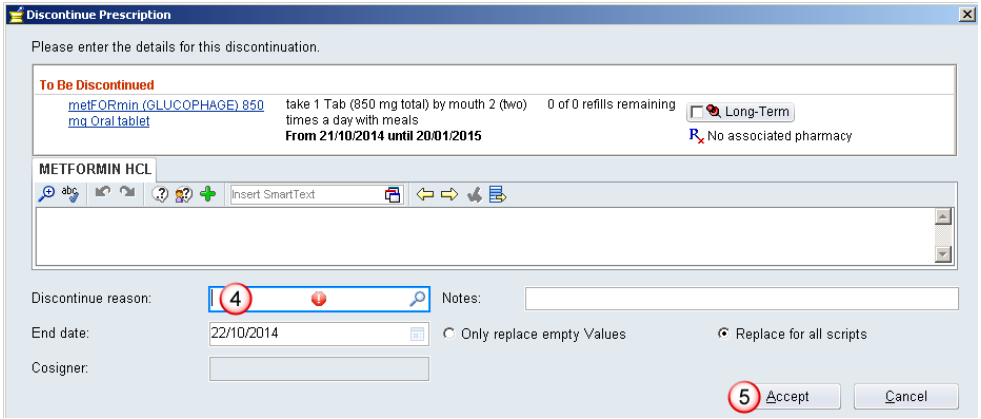


2. Locate an order to be cancelled. You can only cancel one order at a time.
3. If it is a medication, click **Discontinue**. For other orders, click **Cancel**.



Even though there is a **Reprint** button beside medication orders, it only reprints orders that successfully printed the first time.

4. In the **Reason for canceling** field:
   - For medications, type ***Reorder***. Additionally, in the **Notes** field, type ***for reprint***.
   - For other orders, type ***Reprint***.
5. Click **Accept**.



6. Repeat steps 3 through 5 for any remaining orders you wish to cancel.
7. When you are done, return to the Visit Navigator.
8. Open the Meds & Orders section and place the orders again. Once the order is signed, it will print to your assigned printer.

PLACE ORDERS AND OTHER VISIT DETAILS USING A SMARTSET

SmartSets are another way to place orders quickly for your patients. The ***e*CLINICIAN** team typically builds SmartSets for encounters where there is a defined pattern to the orders that you place and the information that you chart. In addition to orders, SmartSets can also contain such things as the reason for visit and follow-up instructions. The Physical Exam SmartSet is an example of a current SmartSet.

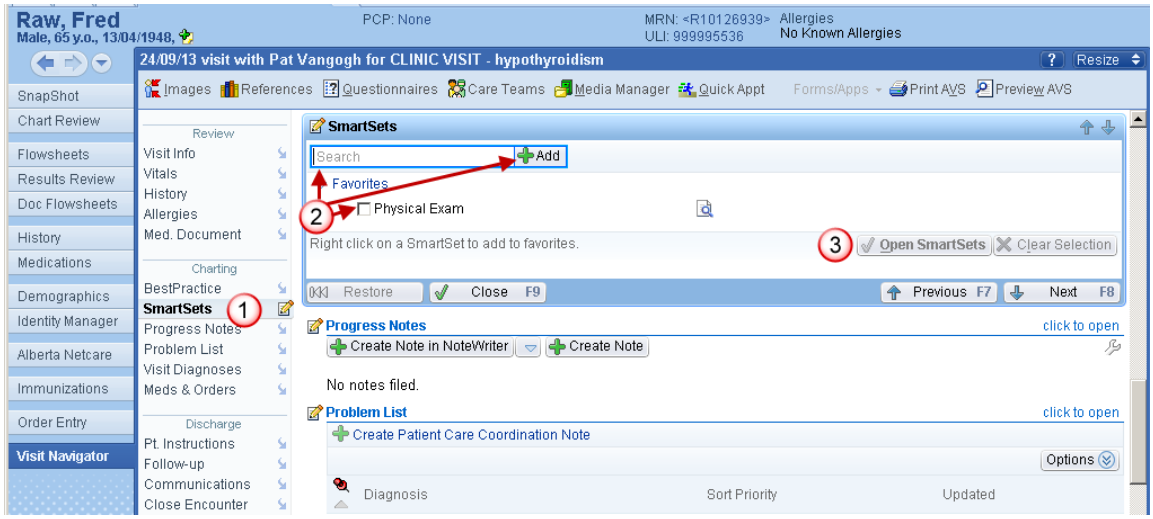
DOCUMENT A PORTION OF YOUR VISIT USING A SMARTSET

A SmartSet can either be opened from the SmartSet section of the navigator, or it can be ***suggested*** based on a reason for visit that was entered for the current encounter.

1. From the navigator table of contents, access the SmartSets section.
2. You can select a SmartSet using the following methods:
   - In the **Search** field, use completion matching.
   - Click the **Add** button.
   - Click the checkbox beside the suggested SmartSet.

   TIP 1: You can preview the SmartSet to see if it is appropriate by clicking the paper and magnifying glass icon beside it.

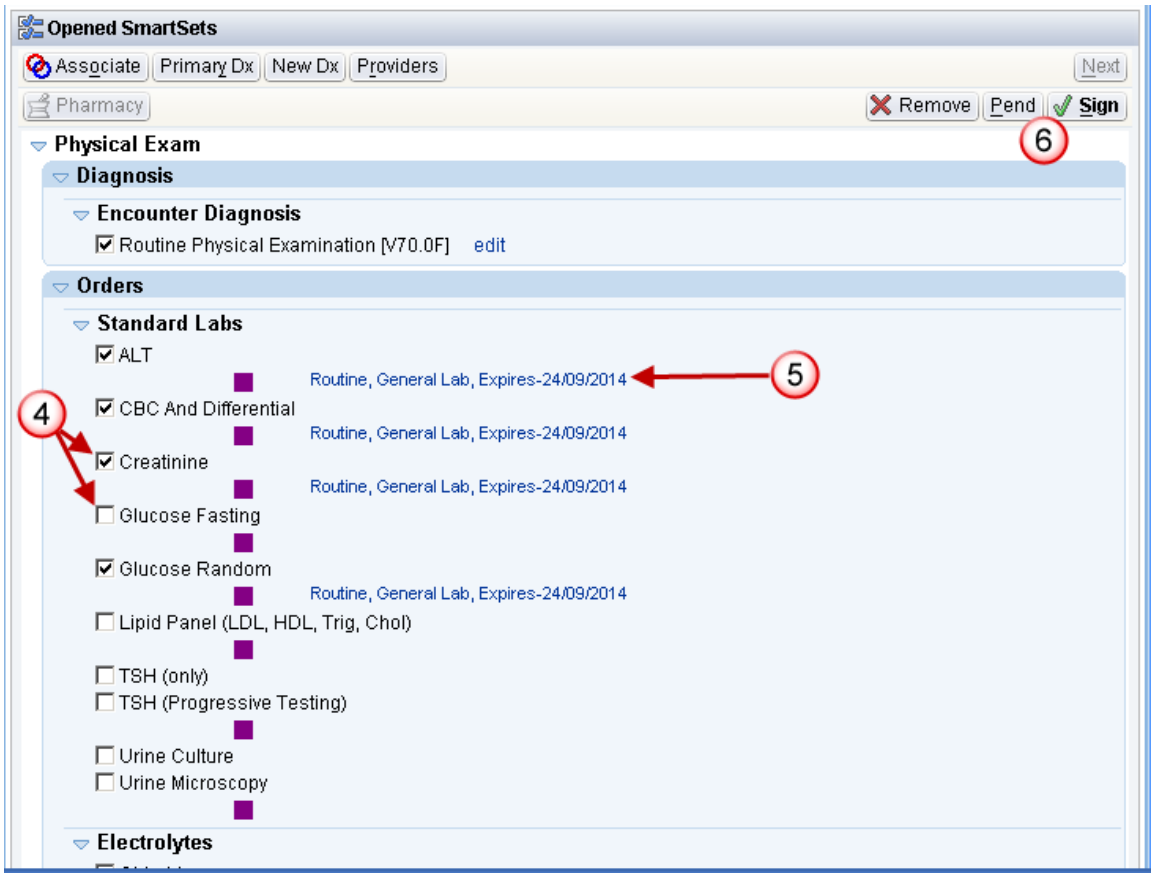
   TIP 2: Right click the SmartSet name to add it as a favorite. The next time you access the SmartSet, it displays with a checkbox under the heading **Favorites**.
3. After making your selection, click **Open SmartSets.**



The appropriate SmartSet displays.

4. Notice that some items are pre-selected. Select or deselect the corresponding checkboxes as required.

5. If you need to change any details relating to a displayed item, click the related Summary Sentence hyperlink.
6. When you are done, click **Sign** or **Pend**.



TIP 3: You can view all of the information populated in the SmartSet in the corresponding sections of the navigator.

TIP 4: If the SmartSet does not contain the item you want to order/document, simply go to the respective section or activity and complete the rest of the orders/documentation for the visit there.

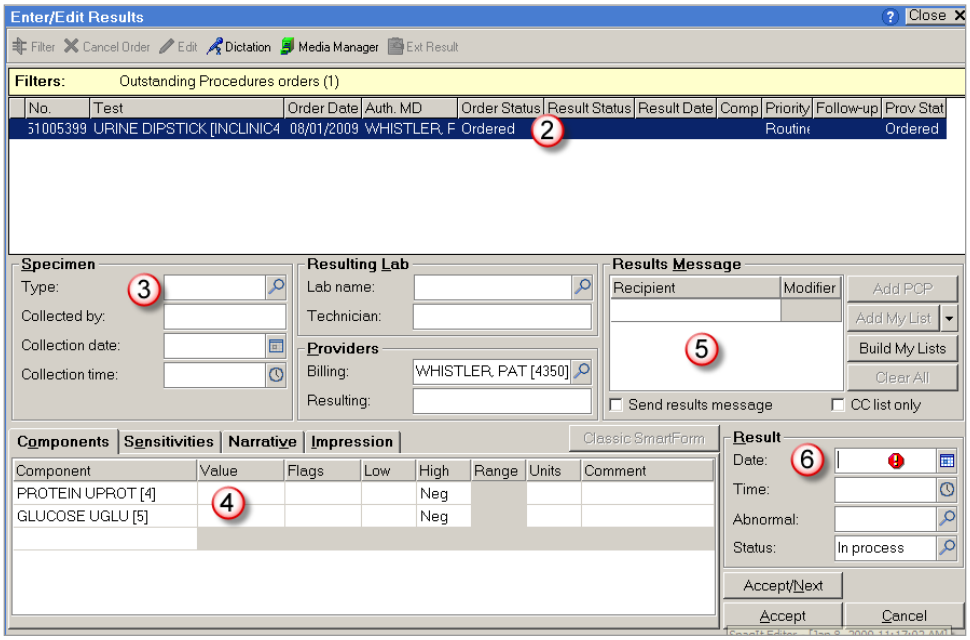
COMPLETE POST ORDER ACTIVITIES

When an order is placed for an In Clinic test or procedure, additional activities may be generated for clinical staff.

These actions may include the documentation of an In Clinic test or procedure and the administration of an immunization. For details on how to document an In Clinic procedure, refer to the topic ***Write a Procedure Note***.

DOCUMENT THE RESULT OF AN IN CLINIC TEST

1. From the lower left-hand section of the patient workspace, select **More Activities** > **Enter/Edit Results**. The Enter/Edit Results activity displays.
2. **Double-click** the test you want to result.
3. In the Specimen section, enter the appropriate information.
4. On the appropriate tab (Components, Sensitivities, Narrative or Impressions) enter the resulting components.
5. Result messages are returned to the ordering provider. To route the result to additional providers, in the Result Message section, complete the details.
6. In the Result section, enter the date and time of the result, indicate whether the procedure was abnormal, and change the status to ***Final***.



7. Click **Accept**.

DOCUMENT AN IMMUNIZATION ADMINISTRATION

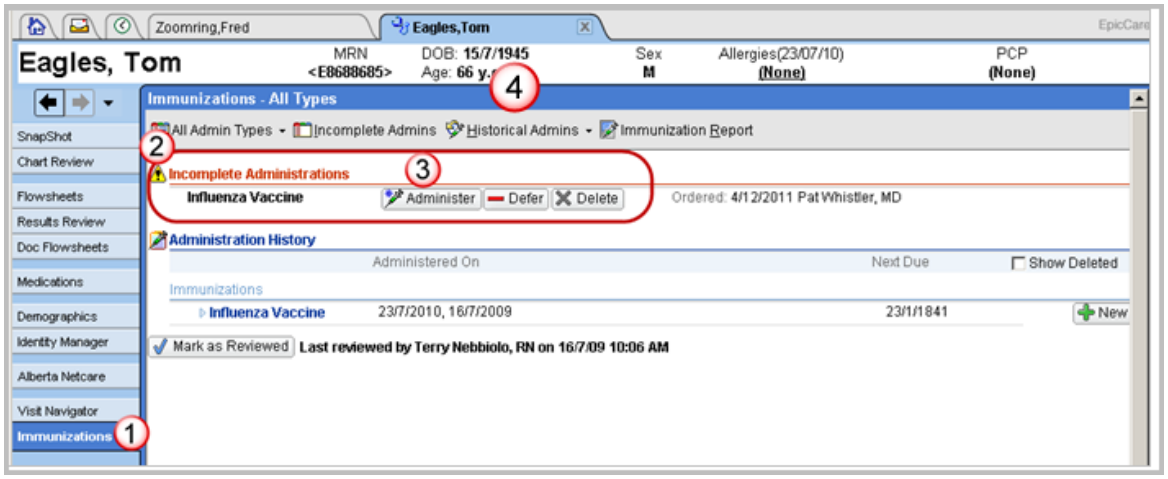
For further details refer to the Self Learning Document: ***Document an Immunization or Vaccine Administration Visit.***

An Immunization must first be ordered within Meds & Orders before you can document the injection administration.

1. From the patient's workspace, select the Immunizations activity.

   TIP: The Immunizations activity can also be found under the More Activities menu.

2. Immunizations that have been ordered, but not yet documented as administered, are listed in the Incomplete Administrations section.
3. Click **Administer** and enter any required details about the immunization, such as the site. will indicate the required fields.
4. From the toolbar, select from the **Historical Admins** menu to document previously administered immunizations.



5. Click **Accept**.

WRAP UP THE VISIT

There are several tasks to consider when wrapping up the patient's visit.

These tasks can include writing a sick note for the patient, creating a letter to a referring provider or writing a consult letter back to the patient's family physician. Other tasks include providing the patient with information to take away with them such as patient instruction handouts or visit summaries.

When charting is complete, you must close the encounter.

The following main topics are covered in this chapter:

- Enter Follow-Up Details and Generate Handouts
- Write Letters
- Close the Encounter

ENTER FOLLOW-UP DETAILS AND GENERATE HANDOUTS

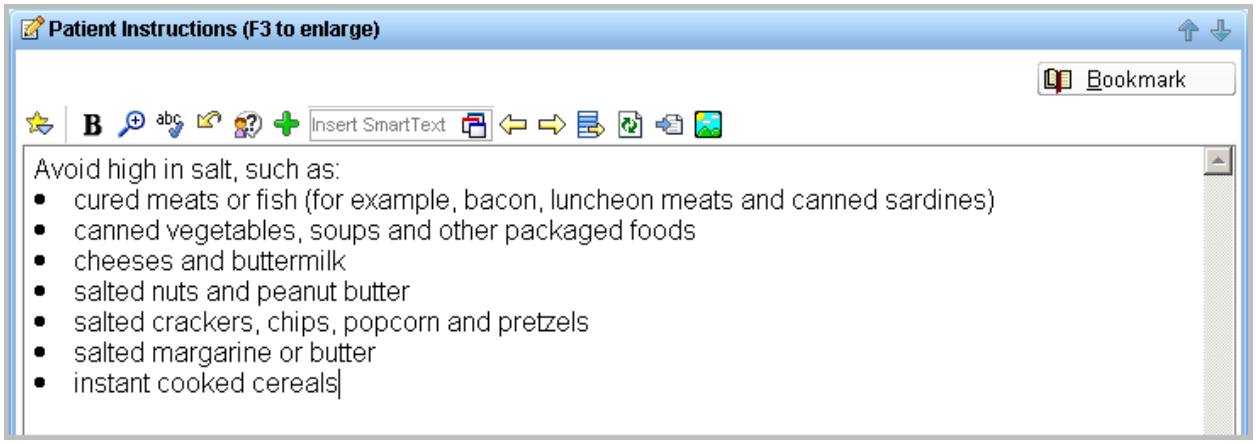
Before you end the visit, you can generate handouts to give to your patient. The handouts can be in the form of patient instructions or a summary of what happened during the visit.

The Follow-up section of the Visit Navigator provides you with an area where you can indicate when the patient should return for their next appointment, communicate instructions to the check-out staff and send a copy of the patient's encounter report to a colleague for comment.

DOCUMENT PATIENT INSTRUCTIONS

The Patient Instructions section of the Visit Navigator allows you to enter information that you want the patient to read and take away with them.

1. From the Visit Navigator table of contents, access the Pt. Instructions section. The Patient Instructions section displays.
2. Enter patient instructions. You can add this information either by directly typing the information, copying and pasting the information from another source, using a SmartTool such as a personal SmartPhrase or using the Clinical Reference activity. For details on how to use Clinical References, refer to the topic ***Use Clinical References***.


Patient Instructions (F3 to enlarge)
Bookmark
Insert SmartText
Avoid high in salt, such as:
cured meats or fish (for example, bacon, luncheon meats and canned sardines)
canned vegetables, soups and other packaged foods
cheeses and buttermilk
salted nuts and peanut butter
salted crackers, chips, popcorn and pretzels
salted margarine or butter
instant cooked cereals

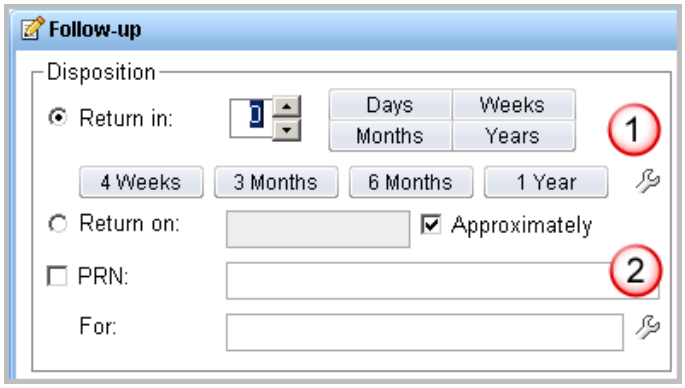
3. You can print Patient instructions directly by using the Print button on the Hyperspace (main) toolbar and then selecting Print Patient Instructions.

TIP: Patient Instructions also display on the **After Visit Summary** report.

SPEED BUTTONS

To increase efficiency in your workflow, speed buttons are now available in the Follow-up section. You have the ability to edit the default buttons and create new ones.

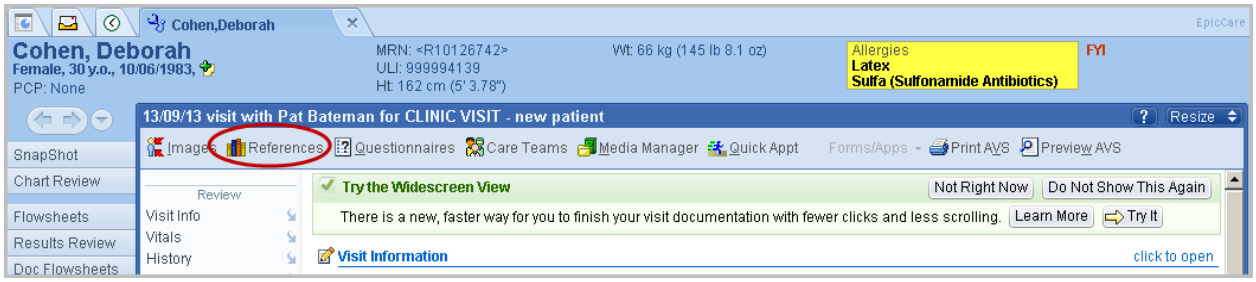
1. To edit or add a new **Return in** speed button, click the corresponding wrench icon.
2. To add a **Reason for Return** speed button, click the corresponding wrench icon.



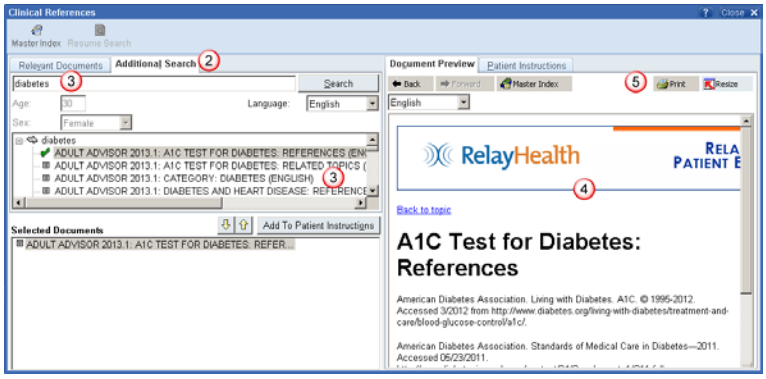
USE CLINICAL REFERENCES

If you want to provide your patient with more information about a particular problem, diagnosis, or medication, you can search for related articles using the Clinical References activity. This activity allows you to print or copy text from McKesson, the clinical reference source used by ***e*CLINICIAN**. The copied text can be incorporated into the Patient Instructions section of the Visit Navigator.

1. From the Visit Navigator toolbar, click References.



2. From the Clinical Reference activity, select the Additional Search tab.
3. In the **Search** field, type the search parameter. Articles matching your search criteria display.

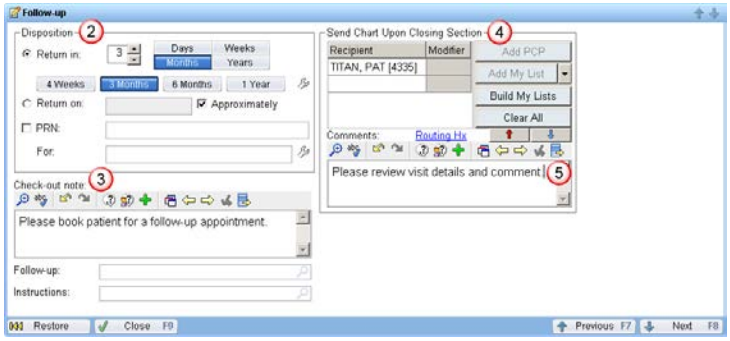


4. Select the appropriate article. The article displays in the right-hand pane.
5. From the Document Preview tab you can click **Print** to print a copy of the article to give to the patient or you can add the content of the article to the Patient Instructions section. To add the contents of the article to the Patient Instructions sections, highlight the article and click **Add To Patient Instructions**.

ENTER FOLLOW-UP DETAILS

The Follow-up section allows you to route a check-out note to administrative support staff to complete any follow-up details for the patient. This is also the section where you can route a chart to another colleague or member of your support team.

1. From the Visit Navigator table of contents, select Follow-up. The Follow-up section displays.



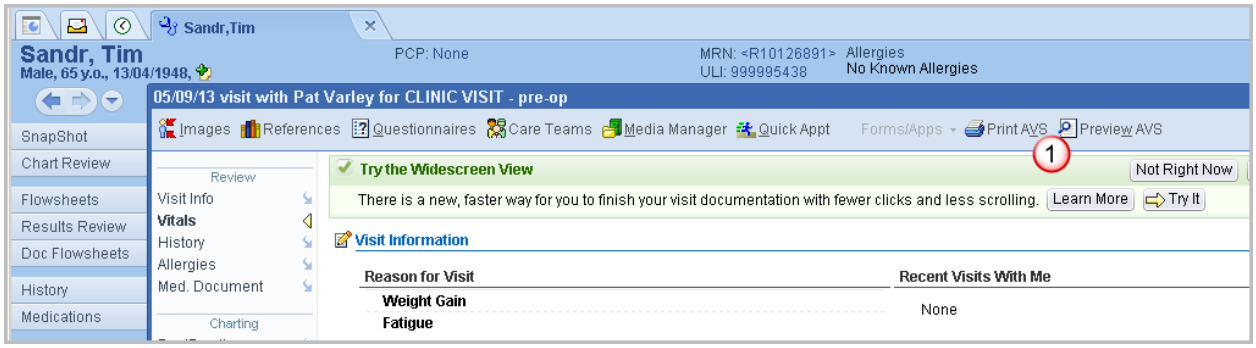
2. In the Disposition area, indicate when the patient should return. The information entered here displays on the After Visit Summary report.
3. To communicate with the staff that checks the patient out of the clinic, type your instructions in the Smart-Tool enabled text box in the **Check-out note** field.
4. To send a copy of the encounter report to another user's In Basket, enter the user's name in the Recipient area. The recipient will receive a CC'd Chart In Basket message.
5. To enter a message for the recipient of the CC'd Chart, use the Smart-Tool enabled text box in the **Comments** field.
6. When you are done, close the section.

PRINT AN AFTER VISIT SUMMARY REPORT

The After Visit Summary Report describes the visit in patient-friendly terms and includes information such as patient instructions, current medications and lab tests ordered. There are several locations from which you can access and print the After Visit Summary. One location is the Visit Navigator toolbar. Another location is within the Snapshot activity.

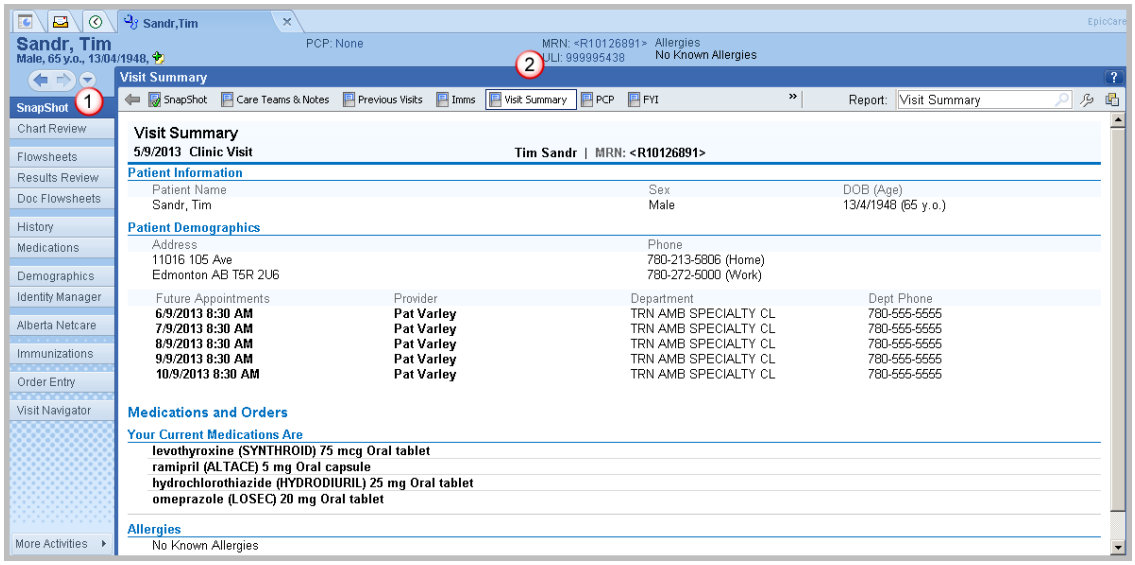
From the Visit Navigator toolbar:

1. Click **Print AVS** or **Preview AVS**.



From the Activity tabs on the left-side:

1. Select the Snapshot activity.
2. From the reports toolbar, click **Visit Summary**.



3. Review the details displayed.
4. To print the report, click **Print** from the Hyperspace (main) toolbar.

The **After Visit Summary** report should be generated only within the context of the current encounter. The report should not be launched when the patient's chart is in **review** mode.

WRITE LETTERS

Letters can be created from both Scheduled and Non-Scheduled encounters. Non-Scheduled encounters include Telephone, Orders Only, Send Letters or Letters (Out) encounters.

The steps to create letters to send to other health care providers and the steps to create letters for patients vary slightly in ***e*CLINICIAN - EMR**.

There are several different workflows which you may use to create and send letters, depending on your clinic's practices. Several of the basic workflows are outlined in detail in the Letter Workflows Self Learning document located on the ***e*CLINICIAN** Training Documents webpage (http://insite.albertahealthservices.ca/11520.asp).

CLOSE THE ENCOUNTER

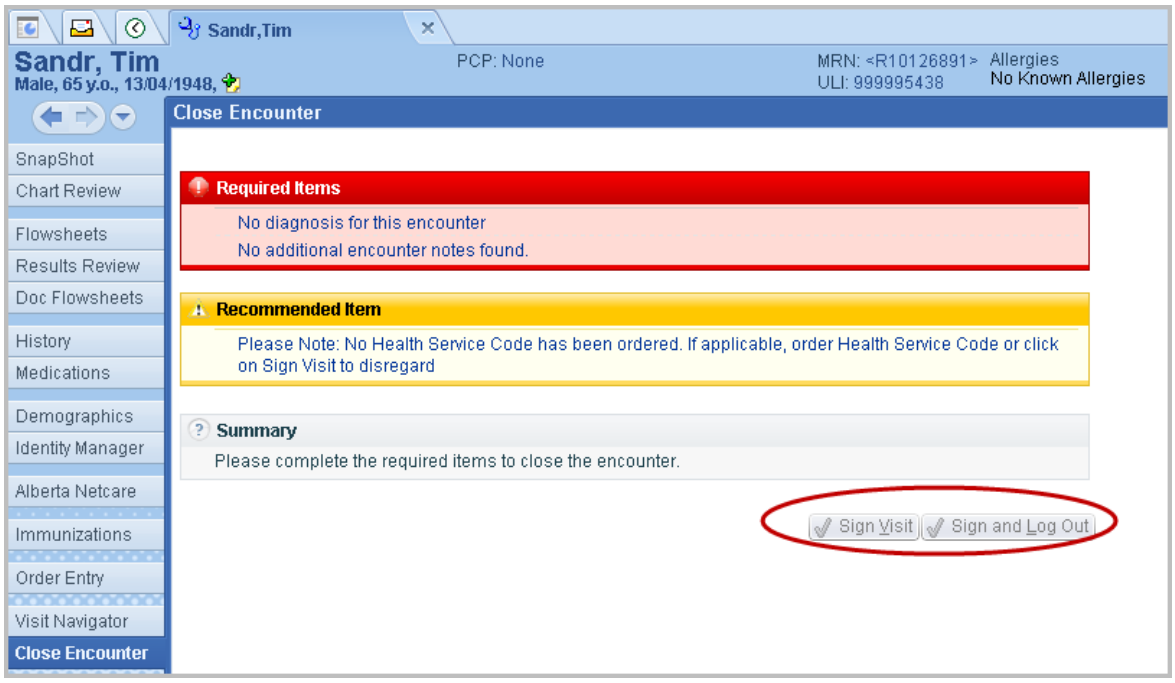
When you are done with all of your documentation, you must close the encounter to finalize your documentation. When you close an encounter, the system also performs checks to ensure that all the necessary information for a particular encounter types has been entered.

Best Practice - Importance of Closing your Encounters

Similar to the In Patient setting, charts in an enterprise ambulatory EMR must be closed in a timely manner. Encounters in a status of **Open** imply that the information in the encounter is incomplete. As a result clinicians looking at the encounter details may fail to act on this information.

If you are the encounter provider and have not closed a chart, you will receive an automated In Basket notification 24 hours later.

1. From the Visit Navigator table of contents, select Close Encounter.
2. If the encounter is missing required information, the Close Encounter activity displays, listing the information you must complete.



3. To quickly jump to the section of the encounter that needs attention, click the appropriate hyperlink.
4. Once all information is complete, select Close Encounter again.

You also have the option to Sign Visit or Sign Visit and Log Out.

PERFORM POST VISIT ACTIVITIES

There are several activities that might be performed after the patient leaves your office. These activities include completing your charting or adding an addendum to an encounter after it has been closed and you discover missing or incorrect information.

This chapter also deals with how to handle encounters that were opened or charted in error and how to indicate that a patient is deceased.

The following main topics are covered in this chapter:

- Find an Encounter to Complete Charting
- Addend a Closed Encounter
- Correct an Encounter Opened or Charted in Error
- Flag Patient as Deceased

FIND AN ENCOUNTER TO COMPLETE CHARTING

You may not have time to complete your charting during the patient's visit.

METHOD 1: FROM THE IN BASKET ACTIVITY

The easiest way to locate open charts is via the In Basket. A My Open Charts In Basket message will be automatically sent to you when a scheduled encounter (e.g. office visit) has not been closed after 24 hours. You can use this reminder to open and complete the chart.

1. To open your In Basket, select the In Basket mini-tab. The In Basket activity displays.
2. Select the My Open Charts In Basket folder. The messages in that folder display in a list to the right.
3. In the upper-right side of the In Basket activity, select the message for the chart you wish to complete.

From the Bottom In Basket toolbar, click **Enc** (or **double-click** the selected message). The patient's workspace displays.

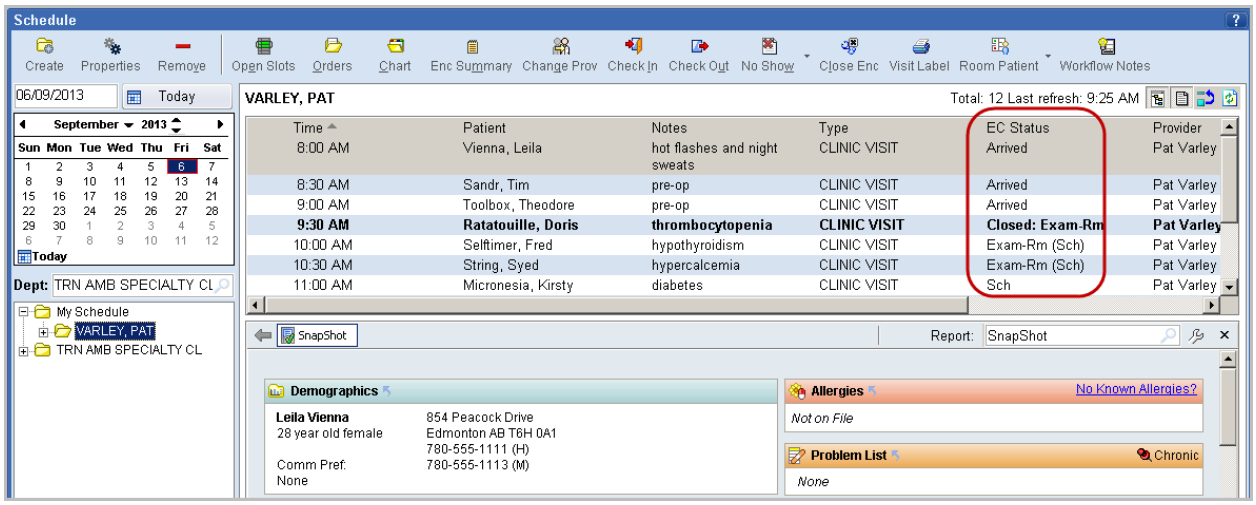
METHOD 2: FROM THE SCHEDULE ACTIVITY

You can quickly locate your open charts using the EC Status column on the Schedule activity. The EC Status are explained below:

EC Status	Explanation
Sch	Appointment has been made but patient has not checked in
Arrived	Patient has arrived and checked in
Exam-Rm (Sch)	Someone has started documenting in the chart, but the patient has not been checked in
Exam–Rm	Patient is in the exam room and someone has logged into the workstation in the exam room and started charting
Comp	Patient has checked out but the encounter has not been closed (documentation incomplete)
Closed: Comp	Patient has checked out and the encounter has been closed
Closed: Exam-Rm	Encounter is closed, but the patient is not checked out

1. To open your schedule, select the Schedule mini-tab. The Schedule activity displays.
2. Use the calendar to select the date on which the encounter took place.
3. Locate the appointment in the upper right-hand pane. If the EC Status indicates ***Exam-Rm (Sch)***, ***Exam Rm***, or ***Comp*** the chart is still open.

4. To re-open the chart and complete your charting, double-click the appointment. The patient's workspace displays.



TIP: Closed encounters display as **Closed: Exam-Rm** in the EC status column.

ADDEND A CLOSED ENCOUNTER

Once an encounter has been closed, you must create an Addendum in order to re-open the chart and update the previous details.

LOCATE AN ENCOUNTER TO ADDEND

METHOD 1: FOR SCHEDULED ENCOUNTERS ON KNOWN VISIT DATES

To addend an encounter for a scheduled visit when the visit date is known, use the Schedule activity to re-open the encounter. The EC Status column can be used to help you find encounters that are still open and may need attention. Closed encounters display as ***Closed: Exam-Rm*** or ***Closed: Comp*** in the EC status column.

1. To open your schedule, select the Schedule mini-tab. The Schedule activity displays.
2. Use the calendar to select the date on which the encounter took place.
3. Locate the patient's visit in the upper right-hand section.
4. Verify that the status of the encounter is ***Closed: Comp*** or ***Closed: Exam-Rm***.
5. To open the encounter, double-click the appointment. The following message appears.

6. To create an addendum, click **Create Addendum**. The patient workspace opens showing an addendum watermark across the right-hand side of the navigator.

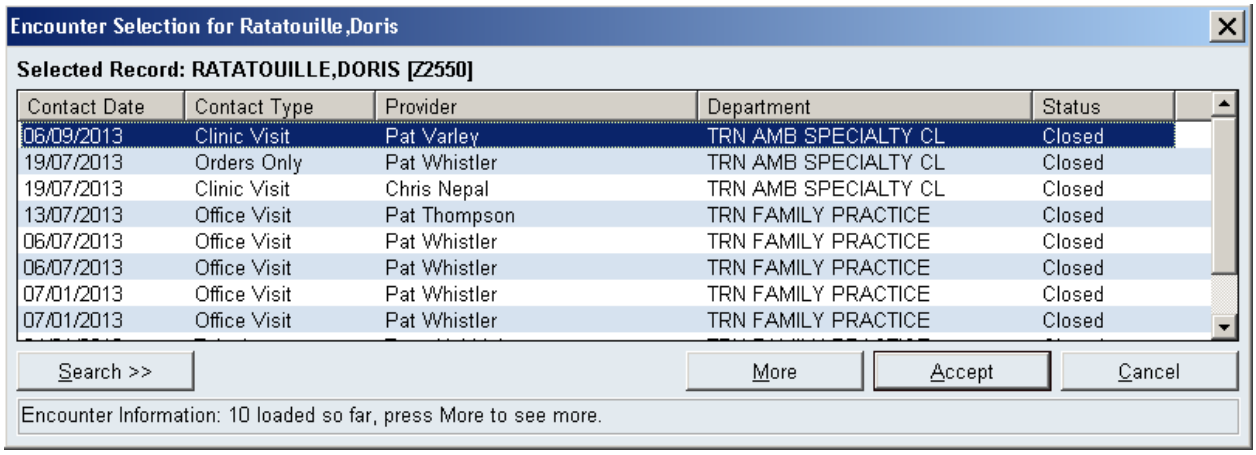
METHOD 2: FOR SCHEDULED ENCOUNTERS WHEN VISIT DATES ARE NOT KNOWN AND FOR NON-SCHEDULED ENCOUNTERS

To addend an encounter for a scheduled visit when the visit date is ***not*** known, and for non-scheduled encounters, you will need to search for the patient's encounter.

1. From the Epic button, select Patient Care > Addendum. The Patient Lookup window displays.
2. Search for the patient using the appropriate search criteria. Refer to the topic ***Find a Patient's Chart when the Patient is not Scheduled***.

   TIP: Consider marking this navigation path as a favorite so that in the future you can access it directly from the Epic button.

3. From the Encounter Selection window, select the closed encounter you want to addend.


Encounter Selection for Ratatouille,Doris
Selected Record: RATATOUILLE,DORIS [Z2550]
Contact Date | Contact Type | Provider | Department | Status
06/09/2013 | Clinic Visit | Pat Varley | TRN AMB SPECIALTY CL | Closed
19/07/2013 | Orders Only | Pat Whistler | TRN AMB SPECIALTY CL | Closed
19/07/2013 | Clinic Visit | Chris Nepal | TRN AMB SPECIALTY CL | Closed
13/07/2013 | Office Visit | Pat Thompson | TRN FAMILY PRACTICE | Closed
06/07/2013 | Office Visit | Pat Whistler | TRN FAMILY PRACTICE | Closed
06/07/2013 | Office Visit | Pat Whistler | TRN FAMILY PRACTICE | Closed
07/01/2013 | Office Visit | Pat Whistler | TRN FAMILY PRACTICE | Closed
07/01/2013 | Office Visit | Pat Whistler | TRN FAMILY PRACTICE | Closed
Search >>
More
Accept
Cancel
Encounter Information: 10 loaded so far, press More to see more.

4. Click **Accept**.

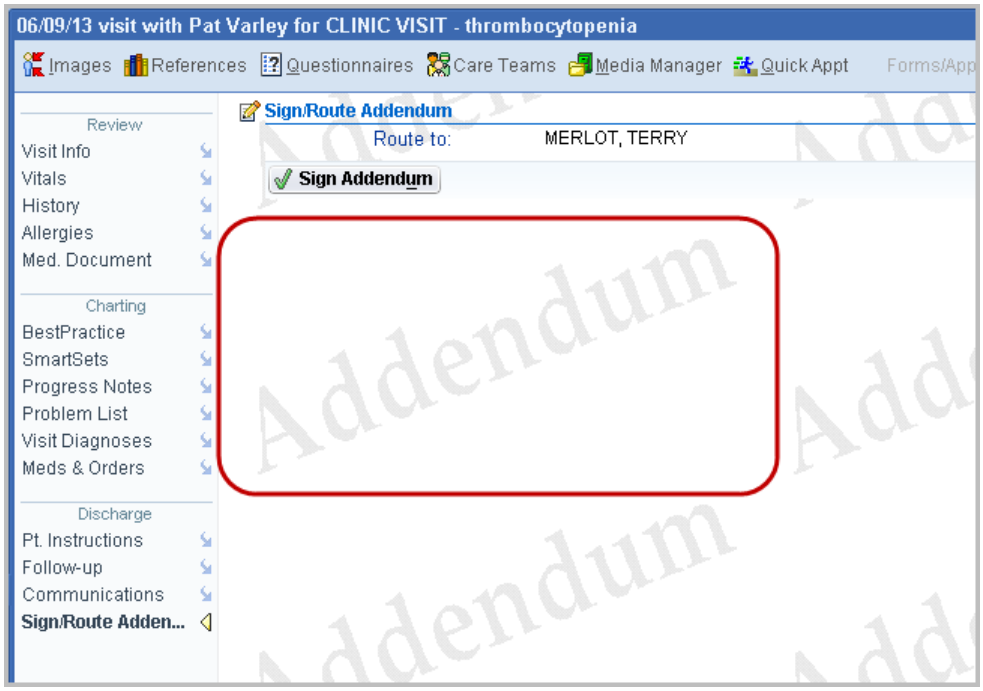
   The patient workspace opens showing an addendum watermark across the right-hand side of the navigator.

ADDEND AN ENCOUNTER

These steps follow from the previous topic ***Locate an Encounter to Addend***.

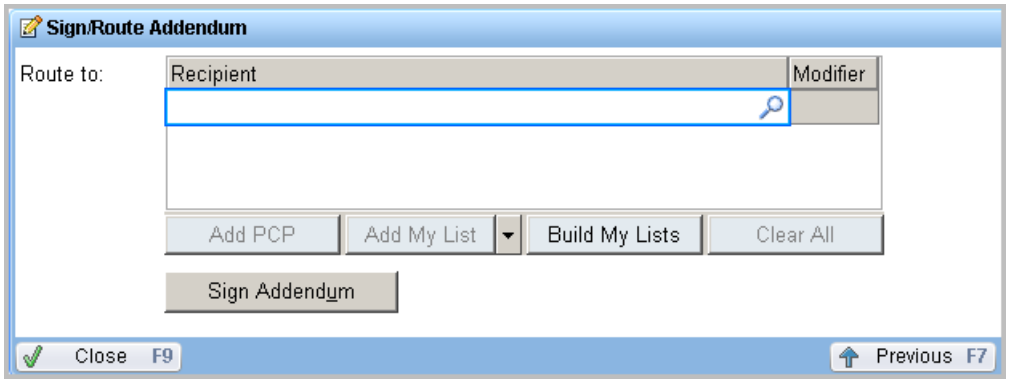
Once an encounter has been closed, you must create an Addendum in order to re-open the chart and update the previous details.

1. Verify that the re-opened encounter displays an Addendum watermark across the right-hand side of the navigator.

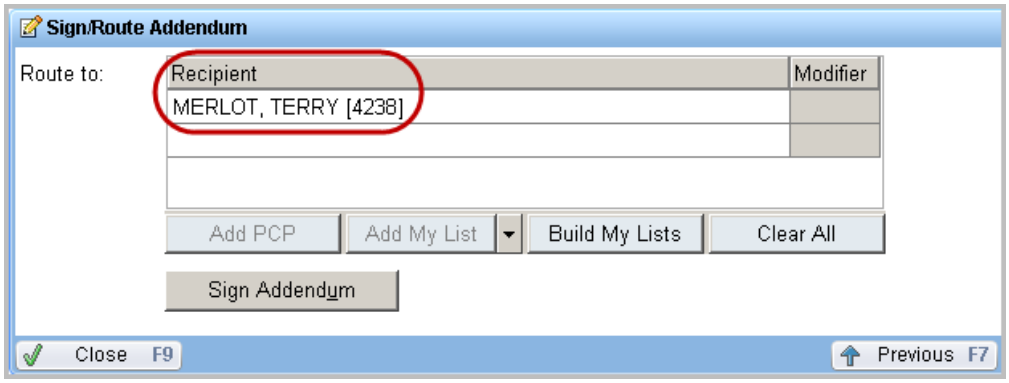


2. From the re-opened encounter, make the necessary changes.

3. To close the addendum, select the Sign/Route Addendum section.
   - If you are the encounter provider, you do not need to route the addendum.



   - If you are not the encounter provider, the encounter provider's name automatically displays in the **Recipient** field. An Addendum Notification In Basket message is automatically sent to their In Basket once you click **Sign Addendum**.



4. Click **Sign Addendum**.

CORRECT AN ENCOUNTER OPENED OR CHARTED IN ERROR

When you have charted on the wrong patient, or you have charted a duplicate encounter for a patient, the following steps must be performed in ***e*CLINICIAN-EMR**:

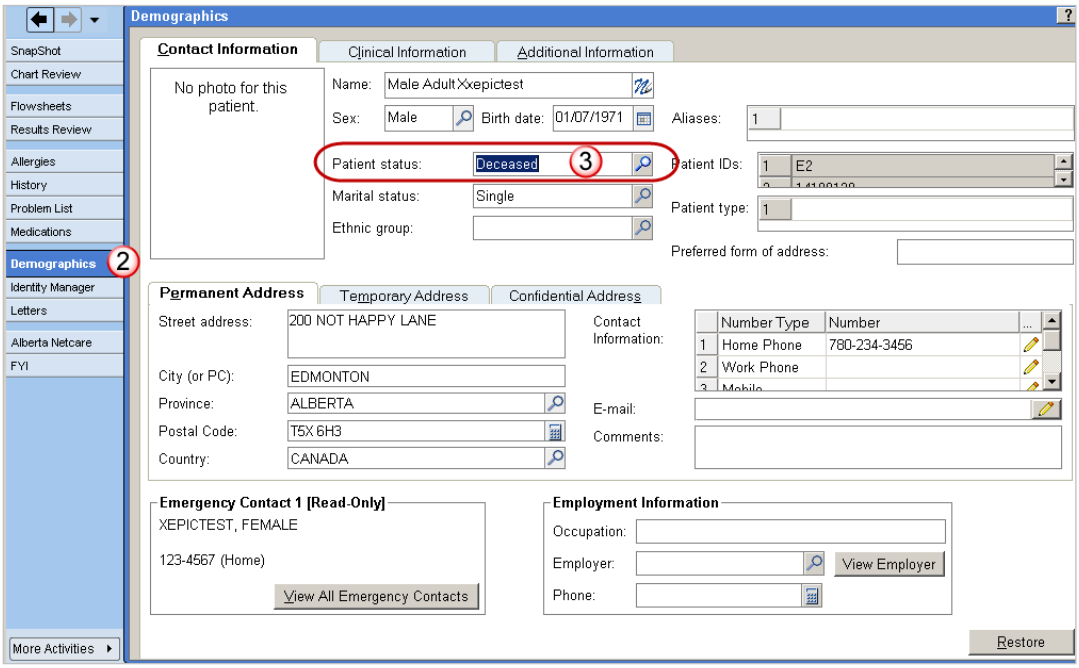
1. Open the appropriate encounter or create an Addendum if the encounter has been closed.
2. Delete any Visit Information or Reason for Call and replace it with ***Error***.
3. Remove any text you entered in the Progress Notes or in the Documentation section. Replace the text with ***Error***. (Do not use the Delete button in the Progress Note)
4. Remove any diagnosis entered and replace it with a diagnosis of ***Erroneous Encounter – Disregard***.
5. Any new information that was entered into the patient's chart must be removed. This may include, but is not limited to, the following examples:
   - Discontinue medications with a reason code of ***Error*** and Note of ***Ordered in Error*** and change the end date to be the same as the start date.
   - Cancel any orders.
   - Delete any information recorded in the Vitals, Allergy, History and FYI sections.
6. Finally, if the patient was provided with printed information, such as prescriptions or lab requisitions, you will need to follow-up with the patient.

TIP 1: If you've opened a Telephone or Refill Encounter by mistake, add Error to the Reason for Visit and close the encounter.

TIP 2: Currently there is no way to indicate that you opened a Letter encounter in error.

FLAG A PATIENT AS DECEASED

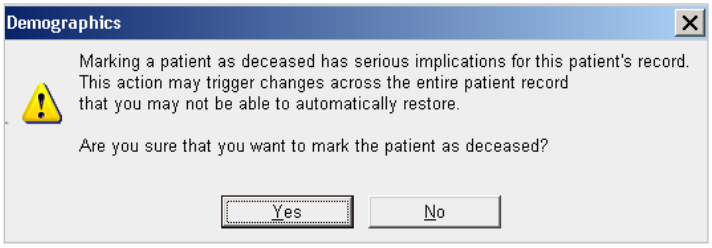
When a patient is marked as deceased in the Alberta Client Registry, the information is automatically transferred to ***e*CLINICIAN** and can be viewed on the Demographics activity.



To avoid the risk that there might be a delay in setting this flag in the Alberta Client Registry, the physician who signs the death certificate has the ability to mark that patient as ***Deceased*** in ***e*CLINICIAN**.

To mark the patient as deceased, perform the following:

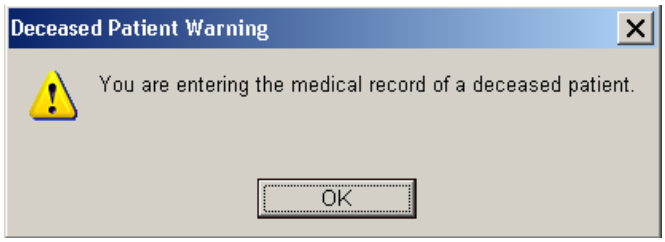
1. Access the patient's workspace.
2. Select the Demographics activity.
3. In the **Patient status** field, change the value to ***Deceased*** and click **Accept**.
4. The following message displays:


Demographics
Marking a patient as deceased has serious implications for this patient's record.
This action may trigger changes across the entire patient record
that you may not be able to automatically restore.
Are you sure that you want to mark the patient as deceased?
Yes
No

5. Click **Yes**.

When the patient is marked as deceased all future-dated appointments are automatically cancelled.

Anyone who accesses the patient's workspace in the future will receive the following warning message:



MANAGE YOUR WORK USING THE IN BASKET

The In Basket is ***e*CLINICIAN - EMR**'s internal communication tool.

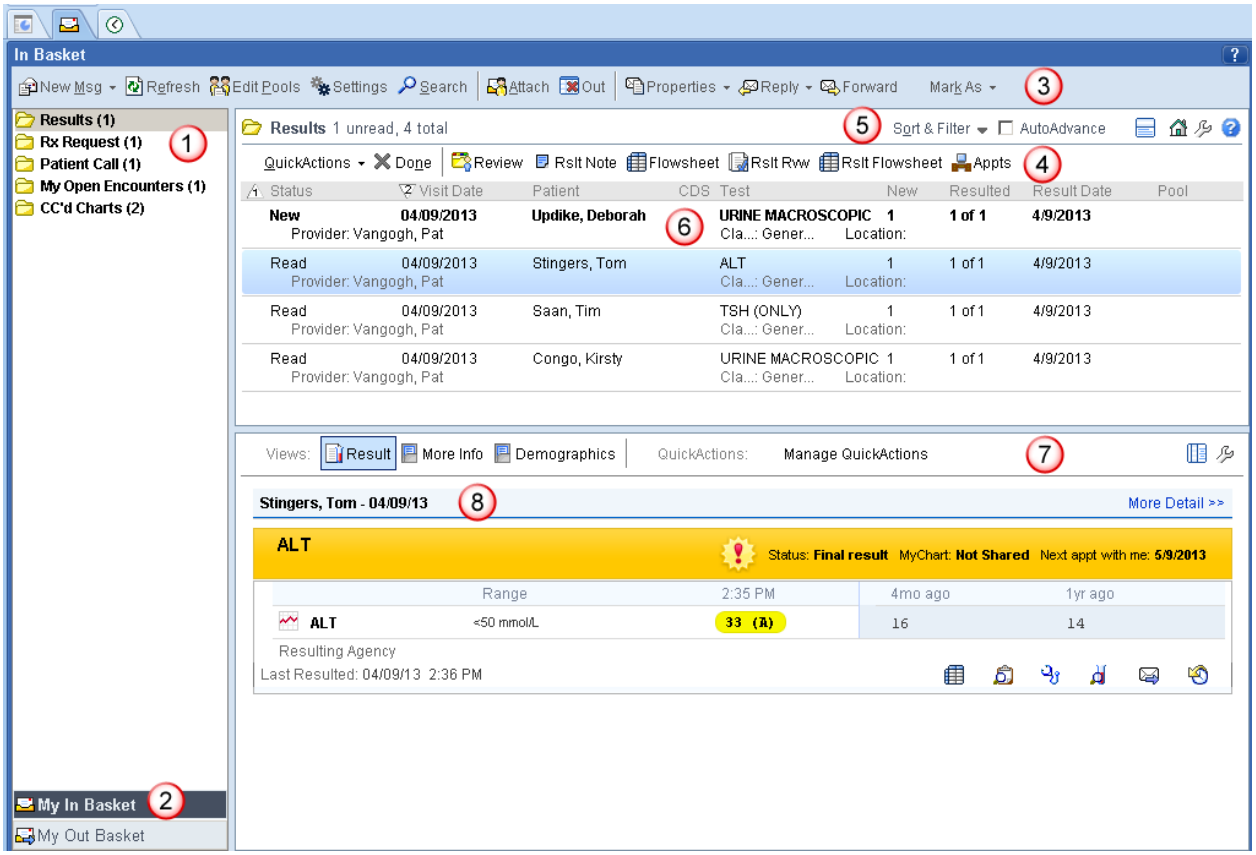
It is critical to understand that working in your In Basket throughout the day will keep your workflows and others' workflows running smoothly. The key to understanding the In Basket is that it is task-based; i.e., it's not just about messaging. The In Basket promotes work flow, and the delegation and completion of tasks through the use of messages. The use of the In Basket is also an important aspect of ensuring patient confidentiality. Users who have access to ***e*CLINICIAN - EMR** should communicate all patient information with one another via the In Basket rather than using email or fax.

The following main topics are covered in this chapter:

- Review In Basket Basics
- Work with In Basket Messages
- Cover your Messages / Share your In Basket
- Work with Result-Related Messages
- Work with Refill Requests
- Work with Messages Related to Completing your Charts
- Work with Telephone-Related In Basket Messages
- Process Letter-Related In Basket Messages
- In Basket as Part of the Clinical Record

REVIEW IN BASKET BASICS

There are several distinct areas of the In Basket workspace.



① **FOLDER LIST PANE (LEFT-HAND PANE)**: The list of folders allows you access to the messages you've received. Folders display only if you have one or more messages of that type. The number of new messages in that folder is displayed in parentheses. Folders that contain new messages display in bold.

② **NAVIGATION BUTTON LIST**: These buttons allow you to switch between your In Basket and Out Basket (where you can view messages you've sent or replied to). If you are covering work for one of your colleagues, an **Attached In Baskets** button also displays. When you open a patient's chart, a temporary folder called Opened Patients displays allowing you to view all messages pertaining to this patient.

③ **TOP IN BASKET TOOLBAR**: This toolbar includes buttons for general In Basket actions and settings that aren't specific to a given message type.

④ **BOTTOM IN BASKET TOOLBAR**: This toolbar includes buttons for actions that are specific to the message type for the folder in which you are working.

⑤ **FOLDER TITLE BAR**: This title bar indicates the name of the folder you have selected as well as the number of unread and total messages. You can select filter options for that folder and choose whether you want to automatically advance to the next message when you are finished with the currently selected message.

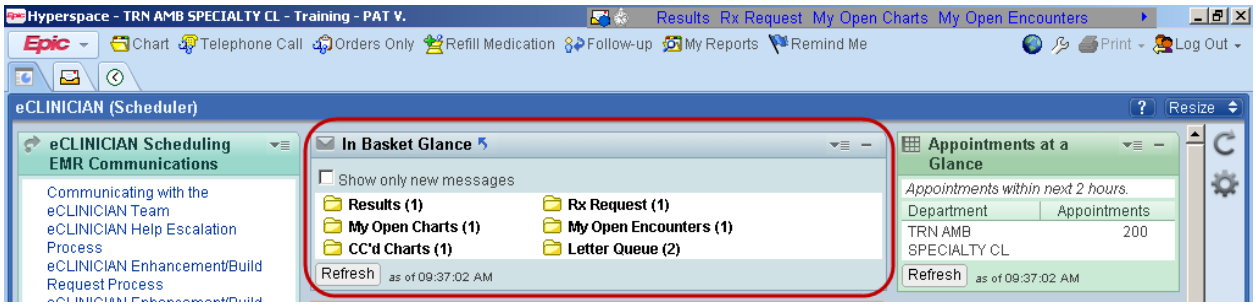
⑥ **MESSAGE LIST PANE (UPPER RIGHT-HAND PANE):** This pane lists all of the messages you've received for a given folder. You can adjust the width of the columns, hide columns and sort messages by clicking the column header or using the controls on the Folder Title bar.

⑦ **MESSAGE REPORT TOOLBAR**: This toolbar includes buttons specific to the message type for the folder in which you are working. You can access a Help report that tells you why you received the message and tips about processing it. It also contains different options for viewing message reports and QuickActions.

⑧ **MESSAGE DISPLAY PANE (LOWER RIGHT-HAND PANE)**: This pane displays the body of the selected message. For some message types, you might also be able to access additional reports using hyperlinks in the message text or the buttons on the available toolbars.

VIEW THE STATUS OF YOUR IN BASKET

Each time you log into ***e*CLINICIAN**, your ***e*CLINICIAN** Dashboard displays a list of your In Basket messages in the In Basket Glance section.



Depending on your setup, you may also see a ***Status bar*** at the top (shown below) or bottom of the Hyperspace screen.

Hyperspace - TRN AMB SPECIALTY CL - Training - PAT V.
Results Patient Call CC'd Charts
Chart Telephone Call Orders Only Refill Medication Follow-up My Reports Remind Me
Print Log Out

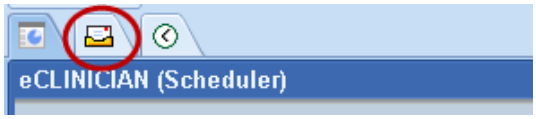
- An In Basket icon displays whenever you have messages in your In Basket.
- A red arrow on the envelope icon indicates that you have a high priority message.
- A blue ball on the envelope icon represents all other priorities (shown above).

OPEN YOUR IN BASKET

There are several ways to open your In Basket.

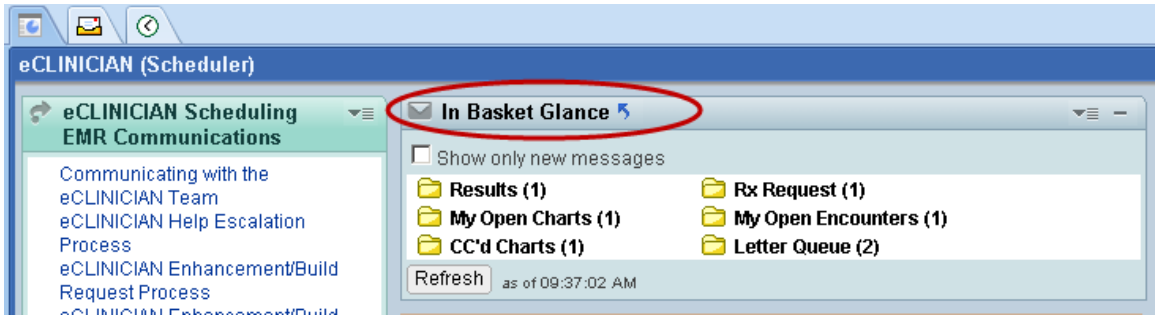
METHOD 1: FROM THE IN BASKET MINI - TAB

Click the In Basket mini-tab.



METHOD 2: FROM YOUR *e*CLINICIAN DASHBOARD

Click the In Basket Glance heading or one of the indicated message types.



METHOD 3: FROM THE STATUS BAR

From the Status bar, click the envelope icon or one of the message types displayed.

TIP: The In Basket status bar displays at the bottom of the Hyperspace window only if you've set your computer's taskbar to the property of **Auto-hide the taskbar**.

SORT AND REFRESH IN BASKET MESSAGES

While working in your In Basket, you can easily sort your messages using the column headers that display. Sorting allows you to organize your messages in a way that makes sense to you and can help you quickly locate certain messages. For example, when working with Results messages, sorting by the Result Date column helps you easily find the oldest resulted tests.

Refreshing your In Basket allows you to watch your list of messages get shorter as you complete messages and mark them as ***Done***.

SORT YOUR MESSAGES

The order that messages initially display are pre-determined. However, you can sort the messages by any column, by clicking the column header. Click once to sort in ascending order. Click again to sort in descending order.

You can also adjust the width of the columns and drag and drop them in a different order to match your preferences.

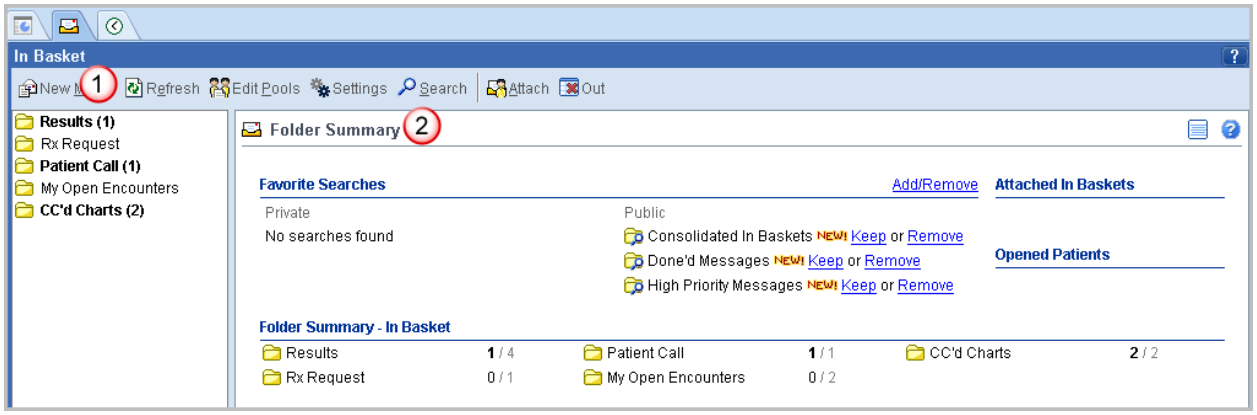
REFRESH YOUR IN BASKET

When you refresh your In Basket, ***e*CLINICIAN** checks for new messages, removes any messages that you marked as ***Done***, and removes any folders that no longer contain messages.

The system automatically refreshes your In Basket at regular intervals while you complete your work and each time you access the activity.

① To refresh your In Basket manually, from the Top In Basket toolbar, click **Refresh**.

② If you don't have any folders selected when you refresh, you'll see an updated Folder Summary in the upper right-hand pane.

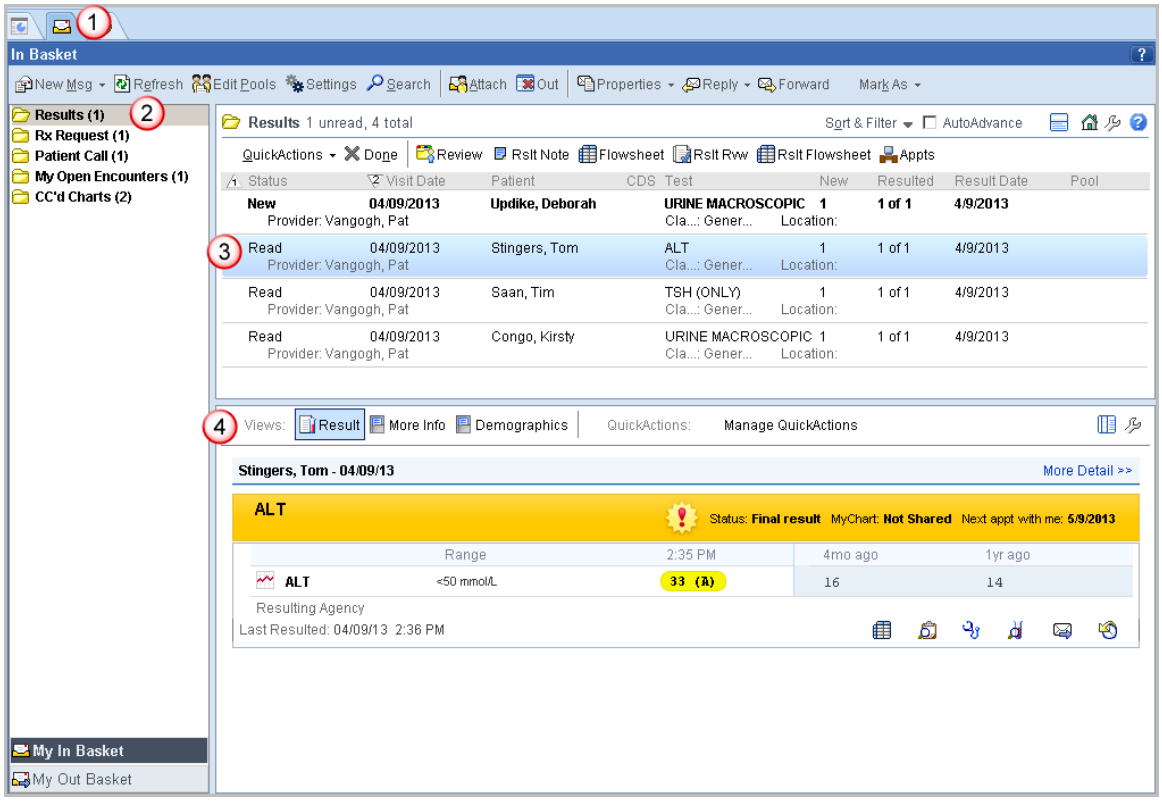


WORK WITH IN BASKET MESSAGES

Most of the time spent in your In Basket involves working with messages you receive, but there are times when you'll need to send a message. For instance, you might send a message when you need to relay a phone message, have someone call a patient, or just ask a co-worker a question. The following topics show how to send and process some of these messages.

VIEW AN IN BASKET MESSAGE

1. Access the In Basket activity.
2. In the Folder List pane, select the folder for the type of message you want to view (for example, Results). The messages in that folder display in the Message List (upper) pane.
3. To read the message contents, select the message.
4. The message displays in the Message Display (lower) pane.

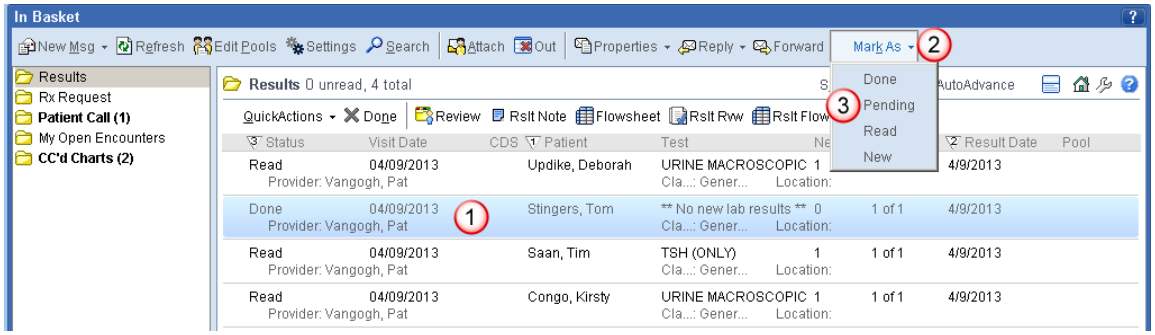


CHANGE THE STATUS OF A MESSAGE

All messages start with a status of ***New***. Once the message is selected in the Message List (upper) pane, the status changes to ***Read***. In some cases, when you perform actions on the message, the message status changes to ***Pend***. The final status of a message is ***Done***.

There may be times when you want to manually change the status of a message. For example, you might always use the status of ***Pend*** to identify messages about which you are waiting for more information.

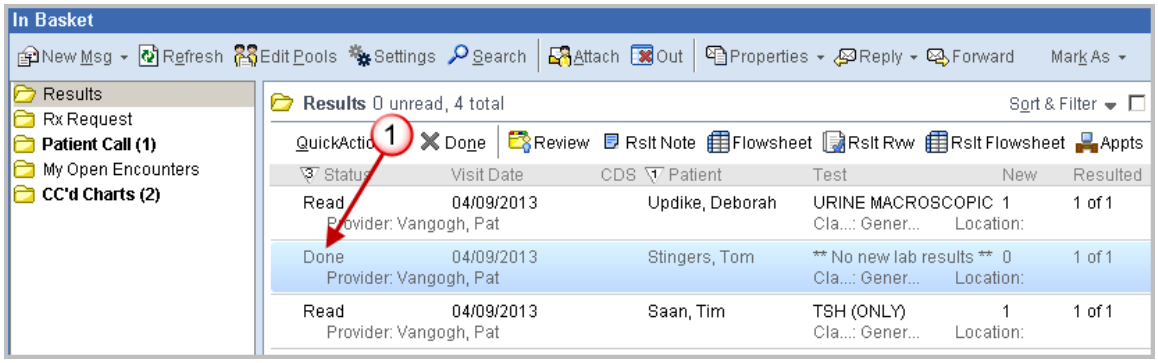
1. In the Message List (upper) pane, select the message.
2. From the Top In Basket toolbar, click the down arrow next to **Mark As**. A menu displays.
3. From the menu, select a new status (for example, Pending). The message then remains in the folder.



REMOVE A MESSAGE FROM YOUR IN BASKET

Once you read a message and no longer want it to display in your In Basket, you must mark the message as ***Done*** to have it removed from your In Basket.

1. With the message selected in the Message List (upper) pane, from the Bottom In Basket toolbar, click **Done**. The Status of the message changes to ***Done***.



Messages marked as ***Done*** are removed from your In Basket the next time the In Basket refreshes. Note that some In Basket messages may have tasks associated with them that must be completed before they can be marked as ***Done***.

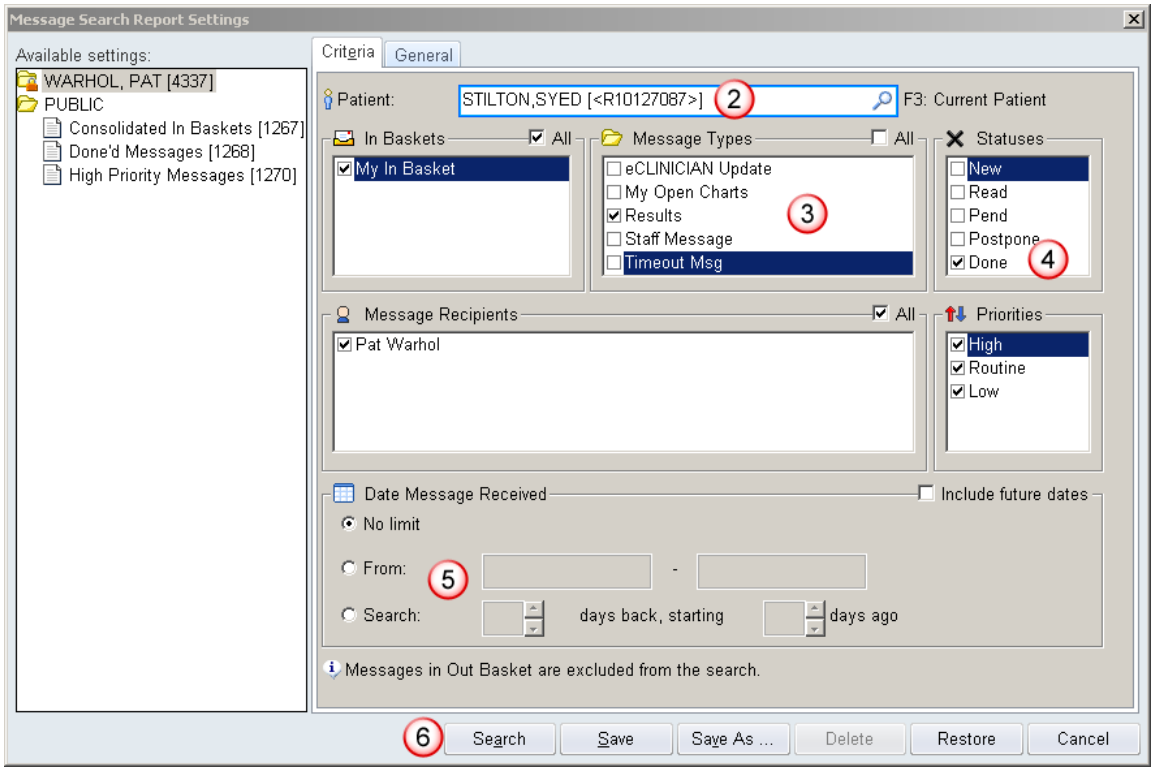
SEARCH YOUR IN BASKET

The In Basket's search functionality allows you to search for messages regarding any combination of the following criteria: a specific patient, attached In Baskets, message type, message status, priorities and date.

1. From the Top In Basket toolbar, click **Search**. The Message Search Report Settings window displays.
2. In the **Patient** field, use completion matching to search for messages pertaining to a specific patient.
3. In the Message Types section, select the appropriate message type(s).
4. To select the messages marked with a specific status, for example ***Done***, in the Statuses section, deselect all of the statuses except for ***Done***.

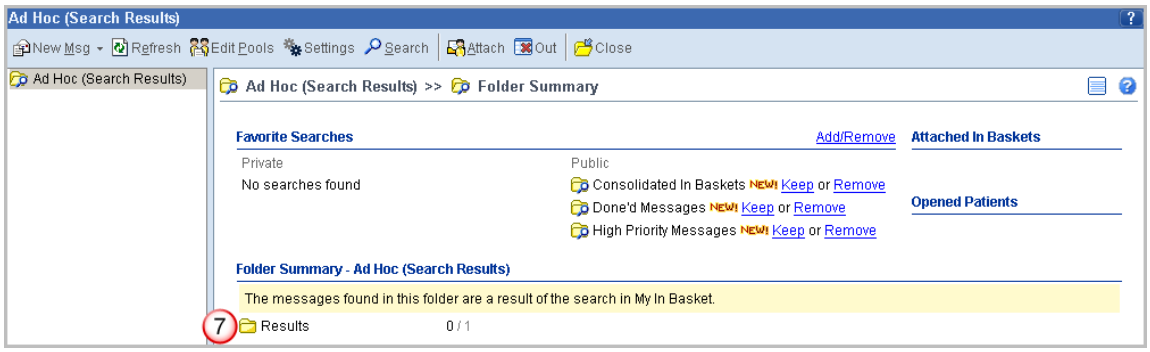
   TIP: You have the ability to retrieve messages marked as **Done** and return them to your In Basket within 60 days of marking the message with this status.

5. If appropriate, in the Date Message Received section, make the necessary selections to search by date or time period.
6. When you are done, click **Search**.



The Ad Hoc (Search Results) window displays.

7. To view the search results, from the Folder Summary – Ad Hoc (Search Results) section, click the folder matching the message type(s) you identified in your search.



RETURN A MESSAGE MARKED AS DONE TO YOUR IN BASKET

If your In Basket has not refreshed, you can quickly change the status of a message from ***Done*** to another status, using the steps outlined in ***Change the Status of a Message***.

Once your In Basket refreshes, you still have the ability to retrieve messages marked as ***Done*** as long as you are within 60 days of the deletion.

1. Perform a search in your In Basket for the target message, as outlined in the previous topic.
2. Change the status of the message.

SEND AN IN BASKET MESSAGE

In ***e*CLINICIAN**, you can send or route messages to the following types of users:

- Individual users
- Classes – A class is a predefined group of users
- Pools – A pool is also a predefined group of users.

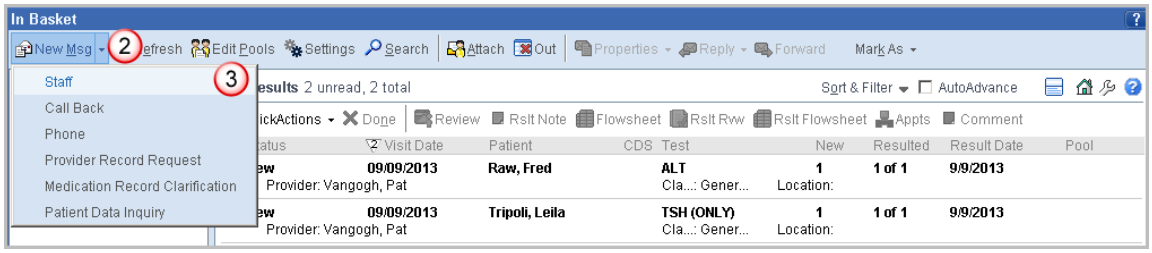
What is the difference between sending a message to a ***Class*** versus a ***Pool***?

When you send a message to a ***class***, everyone in the group receives a separate message. Class messages are typically informational messages.

When you send a message to a ***pool***, everyone in the group sees the same message. Pool messages are typically task-based messages.

To send an In Basket message:

1. Access the In Basket activity.
2. From the Top In Basket toolbar, next to **New Msg**, click the arrow.
3. Select a message type (e.g. ***Staff***).

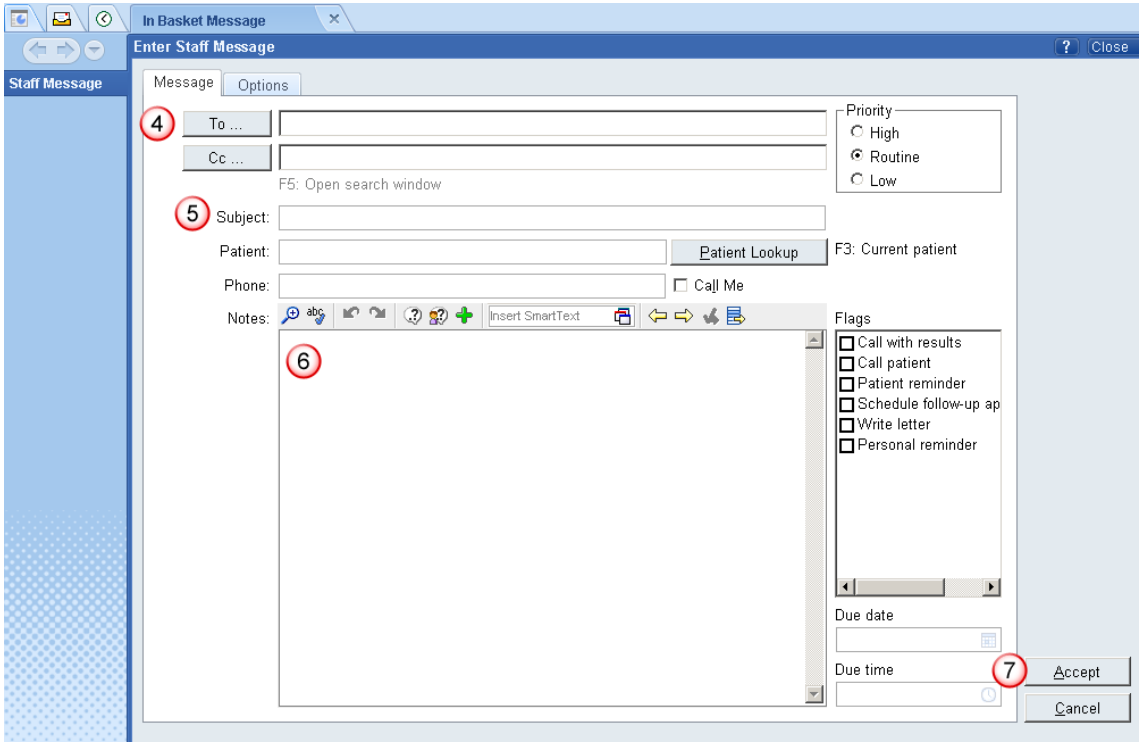


A blank message displays in a new workspace.

4. In the **To** field, use completion matching to search for the name of the person you are sending the message to. Type the name in the format of ***lastname, firstname*** or type the five-digit ID number.

   TIP: You can also use completion matching to quickly enter the name of your recipient. For example, type **smi,ale** to locate Alexander Smith. When sending to multiple recipients, add a semi-colon between recipient names.

5. In the **Subject** field, type an appropriate message heading.
6. In the **Notes** field, type your message. Complete remaining fields as required.
7. To send the message, click **Accept**.



If the recipient of the message has set him/herself as ***Out of Contact***, an Out of Contact window displays to advise you.

Out of Contact
The following users are out of contact.
Pat Vangogh is unavailable through 27/9/2013.
The message may not be handled in a timely fashion by anyone
OK

Options Tab

To send the message at a later date, access the Options tab. In Basket enters today's date by default as the date on which this message should be sent, but you can override this and enter a future date. You can also enter an expiration date and add message flags, if applicable. After a message has expired, it is removed from any recipients' In Baskets.

SEND A MESSAGE TO A POOL

A pool is a predefined group of users set up by the ***e*CLINICIAN** team. When your clinic went live with ***e*CLINICIAN**, a list of your clinic's pool names was created and distributed. If you are unsure of the pool names used by your clinic, contact your Clinic Manager.

The steps for sending a message to a pool are the same as those for sending an In Basket message outlined in the previous topic. However, in the **To** field, type the name of the pool in the form of ***p <pool name>***.

> **TIP**: If you don't know the name of the pool, type ***p ?*** in the **To** field and press ENTER. The Record Select window displays a list of all available pools. You can scroll through the list or enter part of the pool name in the **Search** field and press ENTER.

TAKING OWNERSHIP OF A POOL MESSAGE

Whenever possible, all task-based messages should be sent to pools. This ensures that tasks continue to be actioned when staff are absent from the clinic.

When you send a message to a pool, one recipient must -and only one can- take ownership of the task outlined in the message. To take ownership of a message:

1. Access the In Basket activity.
2. In the Folder List pane, select the folder for the type of message you want to view (for example, Result Notes).

You can tell if a message is a pool message if there is an ***X*** under the PL column.

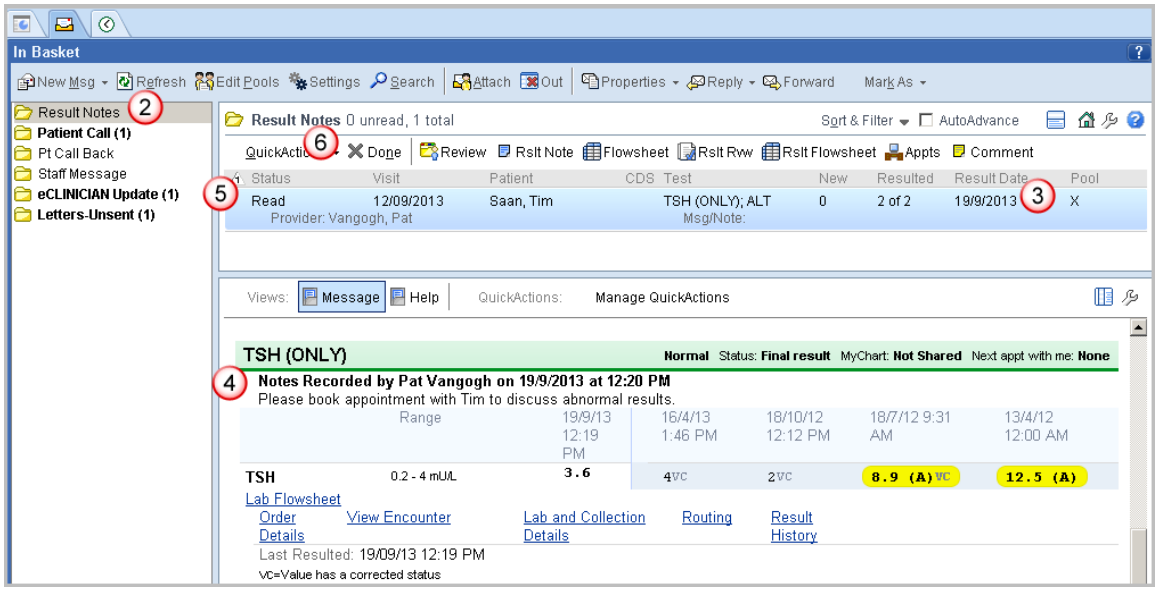
3. In the Message List (upper) pane, select the pool message.
4. In the Message Display (lower) pane, review the message details.
5. The status of the message changes to ***Read***. This indicates to everyone else in the pool that you have taken ownership.

It is important that no members of a pool take ownership of a message that already has a status of **Read** or **Pend** as this means that someone is already performing this task**.**

If you are first to open the message and do not intend to take ownership, you must manually change the message status back to **New**.

> **TIP**: To make ownership more visible, with the message selected, on the Bottom In Basket toolbar, click the **Comments** button, and then type a message (or use a SmartPhrase) to indicate you have taken ownership. When the system refreshes, all pool recipients can then view the comments in the Message Report, under the Completion Message heading.

6. When you complete the task, return to the In Basket message and mark the message as ***Done***. The message is removed from your and all other pool recipients' In Baskets.


In Basket
New Msg
Refresh
Edit Pools
Settings
Search
Attach
Out
Properties
Reply
Forward
Mark As
Result Notes
Patient Call (1)
Pt Call Back
Staff Message
eCLINICIAN Update (1)
Letters-Unsent (1)
2
Result Notes 0 unread, 1 total
Sort & Filter
AutoAdvance
6
Done
Review
Rslt Note
Flowsheet
Rslt Rvw
Rslt Flowsheet
Appts
Comment
Status
Visit
Patient
CDS
Test
New
Resulted
Result Date
Pool
5
Read
12/09/2013
Saan, Tim
TSH (ONLY); ALT
0
2 of 2
19/9/2013
3
X
Provider: Vangogh, Pat
Msg/Note:
Views:
Message
Help
QuickActions:
Manage QuickActions
TSH (ONLY)
Normal
Status: Final result
MyChart: Not Shared
Next appt with me: None
4
Notes Recorded by Pat Vangogh on 19/9/2013 at 12:20 PM
Please book appointment with Tim to discuss abnormal results.
Range
19/9/13 12:19 PM
16/4/13 1:46 PM
18/10/12 12:12 PM
18/7/12 9:31 AM
13/4/12 12:00 AM
TSH
0.2 - 4 mU/L
3.6
4VC
2VC
8.9 (A)VC
12.5 (A)
Lab Flowsheet
Order Details
View Encounter
Lab and Collection Details
Routing
Result History
Last Resulted: 19/09/13 12:19 PM
VC=Value has a corrected status

COVER YOUR MESSAGES / SHARE YOUR IN BASKET

Instead of letting your work accumulate in your In Basket while you're away from the office, you can use the Out of Contact activity to ensure that your work is completed in a timely manner. If one of your patients has abnormal results that need to be reviewed immediately while you are out, another designated provider can access your In Basket, review the results, and take the appropriate follow-up actions.

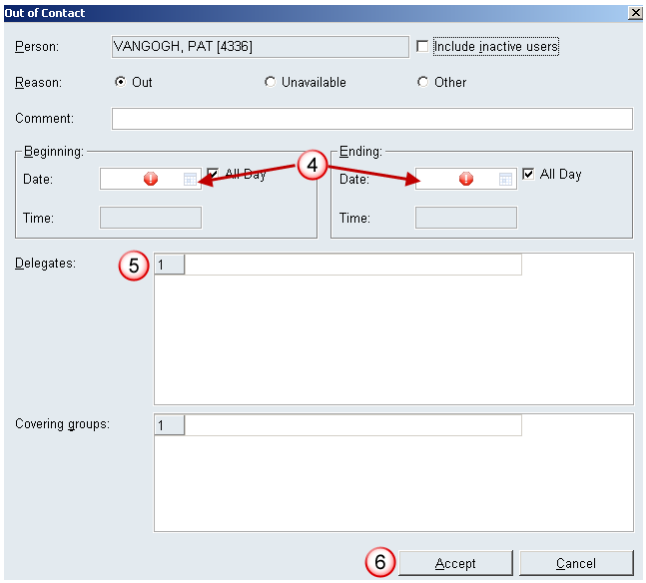
There may also be times when you're not actually unavailable, but you still need someone to help cover your work. You have the ability to grant other users access to your In Basket on an on-going basis. As part of their day to day work, support staff and physicians might also want to share their In Baskets with each other.

ARRANGE FOR COVERAGE OF MESSAGES WHILE AWAY

You can arrange for a colleague to cover for you while you're out of the office or on vacation. The time-period when you are away is referred to as an ***out of contact occasion***. While you are away, your In Basket can be attached to a ***delegate's*** In Basket so that s/he can respond to your messages.

To assign a delegate to your In Basket:

1. Access the In Basket activity.
2. From the Top In Basket toolbar, click **Out**. The Out of Contact activity opens.
3. To create an out of contact occasion, click **New**. The Out of Contact window displays.
4. In the **Date** fields, enter the dates you will be out of the office.
5. In the **Delegates** field, type the name of the user who will be covering for you.
6. When you are done, click **Accept**.Your In Basket appears as an Attached In Basket.



In order to complete the coverage process your delegate must complete the steps in the topic **Attach to Another User's In Basket**.

MODIFY A PREVIOUSLY ENTERED UNAVAILABLE TIME PERIOD

1. From the Top In Basket toolbar, click **Out**. The Out of Contact activity opens.
2. Select an occasion from the Out of Contact Occasions table.
3. **Double-click** the selected occasion or click **Edit** to open the Out of Contact window.
4. Edit information as required.
5. To close the Out of Contact window and save the Out of Contact occasion, click **Accept**.

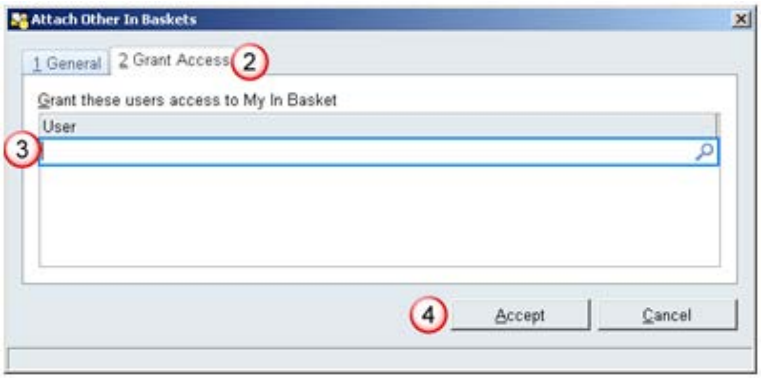
DELETE A PREVIOUSLY ENTERED UNAVAILABLE TIME PERIOD

1. From the Top In Basket toolbar, click **Out**. The Out of Contact activity opens.
2. Select the occasion you want to delete from the Out of Contact Occasions table.
3. Click **Delete** to remove the selected Out of Contact occasion. An Out of Contact confirmation prompt displays.
4. Click **Yes**.
5. Click **Close** to exit out of the Out of Contact workspace.

GRANT ANOTHER USER ONGOING ACCESS TO YOUR IN BASKET

Use these steps to grant a colleague ongoing access to your In Basket.

1. From the Top In Basket toolbar, click **Attach** to open the Attach Other In Baskets window.
2. Select the Grant Access tab.
3. In the **User** field, enter the names of the users to whom you want to grant permission.
4. Click **Accept**.



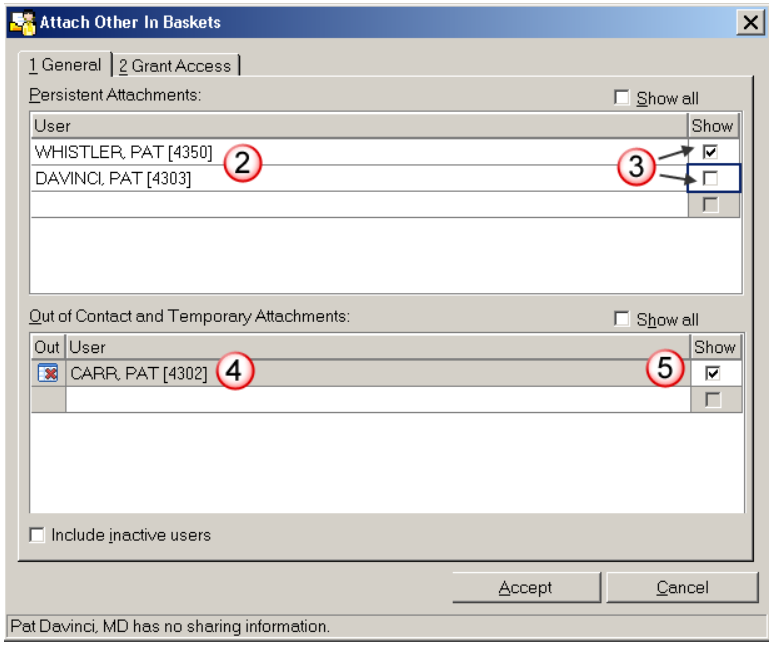
The users to whom you grant access are now able to attach your In Basket using either the **Persistent Attachment** field or the **Temporary Attachment** field under the General tab in the Attach Other In Baskets window.

TIP: To remove the permission after you have given it, simply remove the user's name from the Grant Access tab.

ATTACH TO ANOTHER USER'S IN BASKET

When a colleague has granted you access to his or her In Basket, as described in the topic ***Grant Another User Ongoing Access to Your In Basket***, you must attach his or her In Basket before you can view it.

1. From the Top In Basket toolbar, click **Attach** to open the Attach Other In Baskets window. The General tab displays.
2. To attach to the user's In Basket who granted you a persistent attachment, use completion matching to add the user's name to the **Persistent Attachment** field.
3. To control whether or not you want the user's In Basket to display at this time, select or deselect the Show checkbox. ***Show*** is the default setting.
4. Out of Contact and Temporary Attachments automatically display in the lower area of the window.
5. To control whether or not you want the user's In Basket to display for the Out of Contact or Temporary Attachments, select or deselect the Show checkbox. ***Show*** is the default setting.



VIEW ANOTHER USER'S IN BASKET

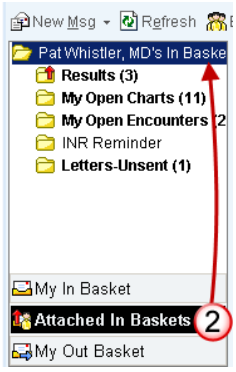
In order to view another user's In Basket, you must first have attached to that user's In Basket. Refer to the topic ***Attach to Another User's In Basket***

to learn how to do this.

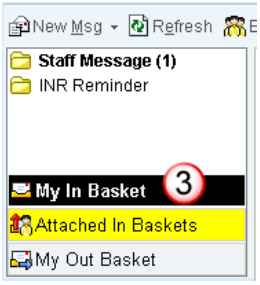
1. Access the In Basket activity.

Starting on the first day that your coverage begins, on the lower left-hand area of the In Basket activity, you'll see an **Attached In Baskets** button.

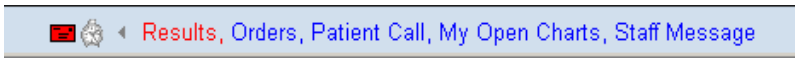
2. To view your colleague's In Basket, click **Attached In Baskets**. Your In Basket folder is replaced with your colleague's In Basket folder.



3. To return to your In Basket, click My In Basket.



Note: For the dates that you cover a colleague's In Basket, the Status bar at the bottom of the Hyperspace window displays the message types for both In Baskets.



WORK WITH RESULT-RELATED MESSAGES

This section describes the actions to take when processing two of the most common result-related In Basket message types: ***Results*** and ***Result Notes***.

Turn Off Delivery of In Patient Results

Physicians can request that the delivery of In Patient results to their In Basket be turned off. When this is done, results still file to the patient chart and are available in Chart Review.

When results are turned off, physicians continue to receive In Patient results from the following:

- Lab and diagnostic imaging results that were copied (CC'd) to the physician
- Provincial Laboratory results
- Private vendor diagnostic imaging results

For more information on results that come into ***e*CLINICIAN** refer to the sections: **Clinical Data Available in *e*CLINICIAN** and **Clinical Data NOT Available in *e*CLINICIAN** .

To request that the delivery of In Patient results to In Basket be turned off, physicians should contact the ***e*CLINICIAN** project team by following the path below:

Epic button > Help > Send a Non-Urgent Help Request to the ***e*CLINICIAN** Team. In the Help Desk window, select Turn Off In Patient Results for In Basket to auto-populate a request message.

Once the change is made, the physician will receive a notification via an In Basket message.

Discontinue the Delivery of Paper Results

Paper laboratory results can be discontinued so that only electronic results are received.

The clinic needs to have been live for a minimum of 90 days and have validated that they are receiving all electronic labs available in ***e*CLINICIAN**.

To begin the process of discontinuing paper lab results, a clinic representative should call the Help Desk at 780 735 4357. The Help Desk will initiate a ticket and submit it to the LIS team.

The LIS team will assist the clinic with the completion of the appropriate paper work, which will include the following required information:

- Clinic Code
- Discontinue request in writing from each physician in the clinic
- Signature from all physicians or a clinic representative

If a physician works in more than one clinic live on ***e*CLINICIAN**, they will continue to receive paper lab results for those clinics that have not completed this process.

To request that "**lab paper reports be discontinued**" for an entire clinic, contact the Help Desk at 780 735 4357 to initiate the process.

REVIEW RESULTS NOT CURRENTLY BEING SENT TO YOUR IN BASKET

Business practices and workflows outside of the control of Information Systems impact the delivery of results to your In Basket.

The reasons why a result may not appear in your ***e*CLINICIAN** In Basket include, but are not limited to, those listed in the following table.

Reason	Example
The result was from a system not interfaced to ***e*CLINICIAN**	Diagnostic Imaging and Laboratory results performed by an AHS facility outside of the Edmonton zone.
	Diagnostic Imaging text reports from Cross Cancer Institute.
	TB Clinic **Example**: Tuberculin Skin Test results.
	Canadian Blood Services **Examples**: Pre-natal, ABO & Rh, Antibody screen
	Alberta Cancer Board Results from the Tom Baker Centre. **Examples**: PSA, Ca 125, CEA.
	DI Text reports from any private community DI providers who do not appear on the ***e*CLINICIAN** Data Source listing. **Examples**: Breast Centre Radiology Mammography & Ultrasound (7121 109 St).
	APPROACH (Alberta Provincial Project for Outcome Assessment in Coronary Heart Disease). **Examples**: Coronary Angiography and Percutaneous Coronary Intervention reports.
	Service performed and resulted by AHS Edmonton facility but the device is not interfaced to a Laboratory Information System (LIS) or a Radiology Information System (RIS) or to ***e*CLINICIAN**. **Examples**: Pulmonary Function tests. The laboratory and ultrasound devices at the Fertility clinic at the Royal Alexandra hospital.
The result was "third party" paid and sent from a private community diagnostic imaging provider	Third party (non-insured, private pay) diagnostic imaging results from private community diagnostic imaging providers **Examples**: Funds Administrative Service (for refugees or immigrants), Canadian Military, Federal Inmates, WCB, Patient Paid, and Corporate Paid.

Reason	Example
You responded "NO" to an applicable ***e*CLINICIAN** Order Entry question	Your response to ***e*CLINICIAN** Order Entry questions drives the delivery of results to the In Basket. **Examples**: If you answer "YES" to the question "ECG to be read by DKML Panel?", DynaLIFE results the ECG and the electronic result returned to you via your In Basket. If you answer "NO" to this question, you need to provide the name of the doctor who will interpret the ECG. In this case, DynaLIFE sends the ECG readings to the physician indicated on the order. The doctor who interprets the ECG sends the paper result directly to you.
Your name was not added to receive the result	**Example 1**: Workflow determines whether or not you receive the result. For a particular test, the process used by a site or department may be to CC the result to the family physician, if the family physician is mentioned in the dictated result. For the same test done at a different site or department, the process used may not CC the result to the family physician. **Example 2**: Registration interfaces and processes impact which results are sent to the In Basket. In the case of Dictaphone (regional transcription system), if the VAX or Tandem ADT system contains the name of the patient's family physician, the transcription report is automatically CC'd to the family physician. When transcriptions are performed in other areas that do not use the Dictaphone, no provision of electronic results exists. This would include several specialists who use personal or private systems and staff for their transcription needs.
Your name was incorrectly entered by the sending system	

Each clinic must have a formal process in place for the routing of paper results that are not sent electronically to the ***e*CLINICIAN** In Basket.

REVIEW A RESULT MESSAGE

The In Basket activity instantly provides you with results as they are entered in the system.

1. Access the In Basket activity.
2. In the Folder List pane, select the Results folder.
3. In the Message List (upper) pane, select the message.

High-priority and abnormal results are indicated by a red arrow and a red exclamation point, respectively. All abnormal results are also marked as high priority.

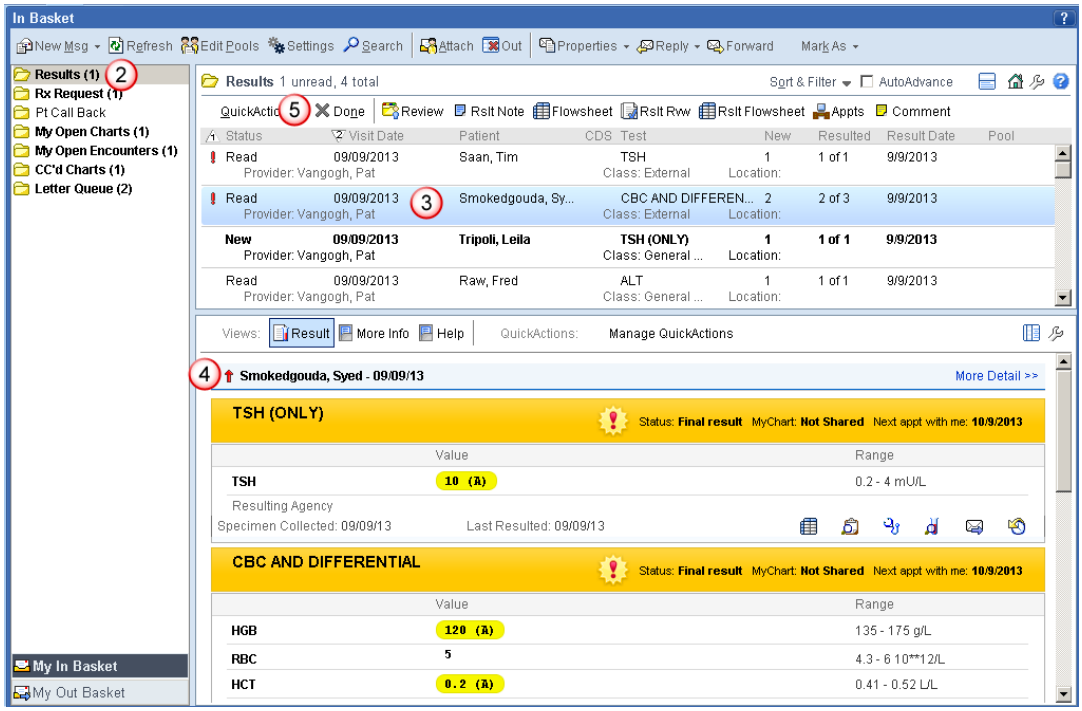
Within the Results message itself, abnormal components are highlighted in yellow and followed by "(A)".

Also, lab results that are flagged as Normal, Abnormal or Critical appear with a green, yellow and red Message Report banner, respectively. Any results that are not flagged appear with the neutral coloured banner associated with the Hyperspace theme in use.

4. In the Message Display (lower) pane, review the message details.

When the status of the Results message changes from ***New*** to ***Read***, ***e*CLINICIAN** stamps the result with your name and the date that you reviewed the result. This information is viewable on the corresponding Result report in the Chart Review activity.

5. From the Bottom In Basket toolbar, click **Done**. This message is removed from your In Basket the next time the In Basket refreshes.



RESPOND TO A RESULTS MESSAGE

The results that you receive may require follow-up actions. To detail the actions required and to route the actions to the appropriate recipients, use a Result Notes message.

Result Notes messages are filed in the patient's chart along with the original result. Having the result as well as the follow-up actions all together in the patient's chart is an important aspect of patient safety.

1. With the appropriate Results message selected, from the Bottom In Basket toolbar, click **Rslt Note.** The Result Note window displays.
2. In the Select Orders section, select the appropriate test(s) that relate to your note.
3. In the **Result Note** field, type your instructions for the selected test(s).

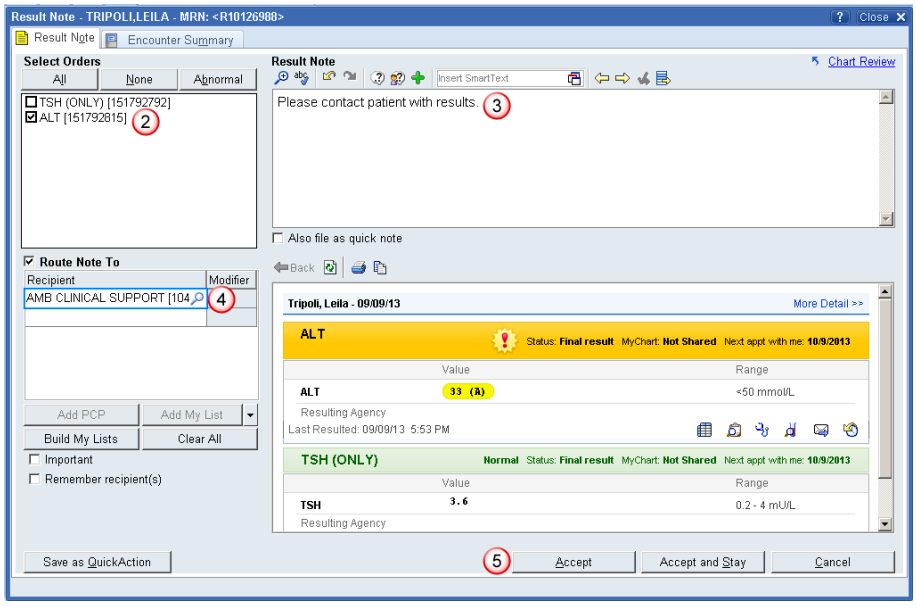
   TIP 1: Do not use the **Also file as quick note** checkbox when processing results. This feature creates an additional progress note that has no reference to the original result.

4. Under the Route Note To checkbox, in the **Recipient** field, type the name of the person(s) you wish to send the note to (e.g. your support pool or another physician).

   TIP 2: If you anticipate routinely routing Result Notes to the same recipient(s), select the Remember recipient(s) checkbox. The system automatically populates the **Recipient** field with this information in the future.

Notice that on the bottom left of the Result Note window, there is a **Save as QuickAction** button. QuickActions allow you to complete workflows in fewer steps, saving you time. To learn about creating and managing QuickActions, refer to the **Personalize *e*CLINICIAN** section.

5. Click **Accept**.



The In Basket window redisplays. Notice that the status of the message is now ***Pend***.

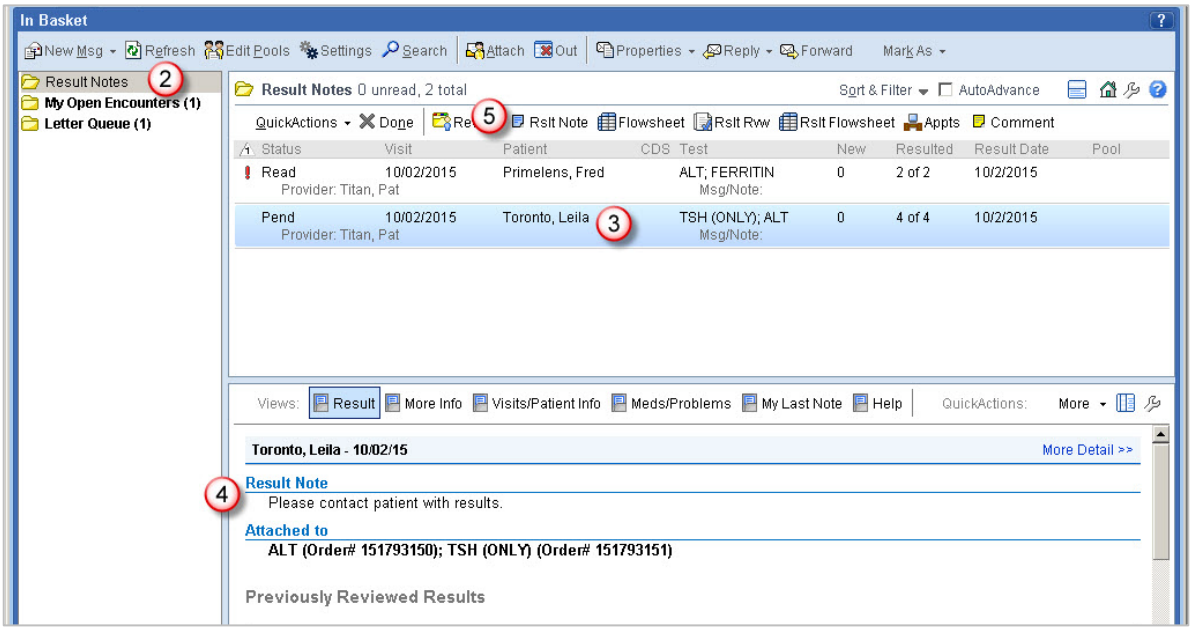
6. To mark the message as complete, from the Bottom In Basket toolbar, click **Done.** When your In Basket refreshes, this message disappears from your Results folder.

Your Result Note is routed to the indicated person(s) in the form of a Result Notes message. The person who receives the Result Note should enter their comments (e.g. "Pt. aware of test results" or "Pt. booked for follow-up") as another Result Note, which is demonstrated in the next topic.

The repeated use of the Result Note functionality is the best way to quickly view all communication about a result.

RESPOND TO A RESULT NOTES MESSAGE

1. Access the In Basket activity.
2. Select the Result Notes folder. The messages in that folder display in the Message List (upper) pane.
3. Select a Result Notes message.
4. In the Message Report (lower) pane, view the message details and perform any assigned tasks.

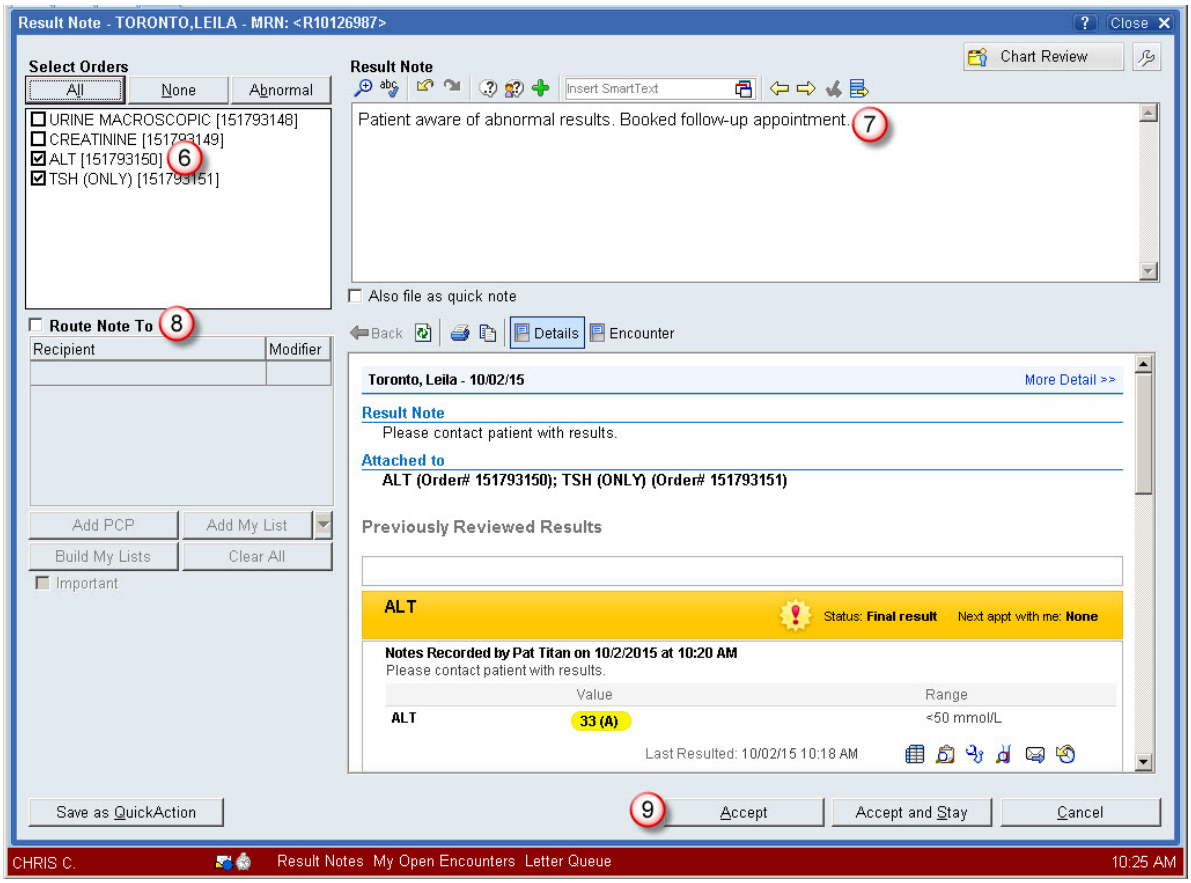


The Result Notes message basically serves as a springboard for the creation of additional notes and for any actions you might need to take, such as:

- Contact the patient to pass along the result
- Book a follow-up appointment for the patient
- Place follow-up orders for the patient

The steps for these last two items are documented in the two topics which follow.

5. Once you have completed the assigned task(s), on the Bottom In Basket toolbar, click **Rslt Note**. The Result Note window displays.
6. In the Select Orders section, select the appropriate order(s) that apply to the note.
7. In the Result Note box, type an appropriate note.
8. Result Note messages can be routed back to the sender as verification that action was taken. If you do not wish to route your message, deselect the Route Note to checkbox.
9. Click **Accept**.



The In Basket activity redisplays, with the Result Notes message highlighted and opened.

TIP: This and any subsequent Result Note messages remain attached to the order. Learn how to view Result Notes in the topic **View Result Notes in the Patient's Chart**.

10. If no further action is required, click **Done**.

BOOK A FOLLOW-UP APPOINTMENT FROM A RESULT NOTE

If you have the appropriate security, you can schedule a follow-up appointment for the patient from the Result Note window.

1. With the Result Note window still displayed, from the Epic button select Scheduling > Appts. The Patient Lookup window displays showing the patient's record in the 'Shortcut to Open patients' section.

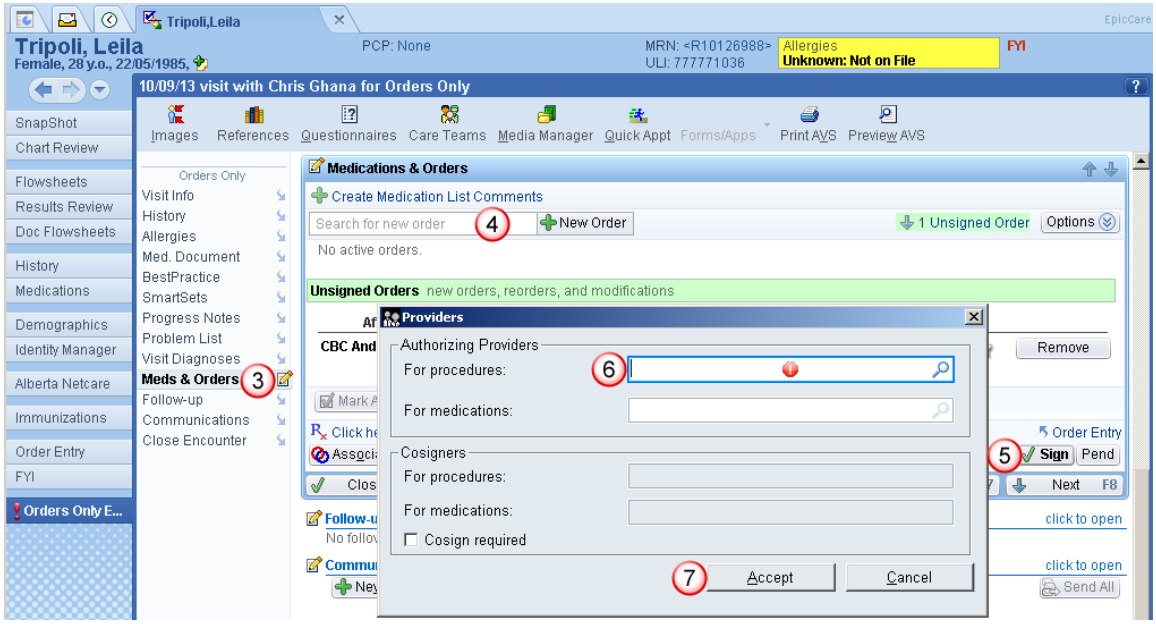
   TIP: Depending on your security role, an Appts button may also be available to you from the Hyperspace (main) toolbar.

2. Select the patient record. The Appointment Desk activity displays.
3. From the Appointment Desk toolbar, click Make Appt.
4. Enter the required information in the Appt notes, Visit Type and Providers fields.
5. To use the Auto Scheduler to find the next available appointment, in the View Options section, select the Auto Search checkbox and click Search. The next available appointment displays in the Recommended Solution window.
6. To accept the displayed appointment, click Schedule. The Appointment Review window displays.
7. Click Accept to close the Appointment Review window.
8. Click Accept to close the Appointment Information activity. The Appointment Desk re-displays.
9. Close the patient's workspace. The Result Note window redisplays.
10. In the Result Note section, type your note including the date of the future appointment.
11. If no further action is required, click Accept.
12. Click Yes at the prompt to indicate that you do not wish to route the message. The In Basket activity redisplays.
13. With the Result Note message highlighted, click Done.

PLACE FOLLOW-UP ORDERS FROM A RESULT NOTE

1. With the Result Note message highlighted or with the Result Note window open, from the Hyperspace (main) toolbar, click **Orders Only**. The Patient Lookup window displays showing the patient's record in the Shortcut to open patients section.
2. Select the patient record. The patient's workspace opens showing the Orders Only Encounter navigator.
3. From the navigator table of contents, access the Meds & Orders section.
4. Using the **Search for new order** field or the **New Order** button, order the required tests or procedures.

5. Click **Sign**. A Providers window displays, prompting you to enter an authorizing provider.
6. Type the name in the format of ***lastname,firstname***.
7. Click **Accept**.



8. Complete any other details in the encounter.
9. Close the encounter. The encounter and the patient's workspace close. The Result Note message redisplays.
10. Create a Result Note as outlined in the topic ***Respond to a Result Notes Message*** in the Manage Your Work Using the In Basket.

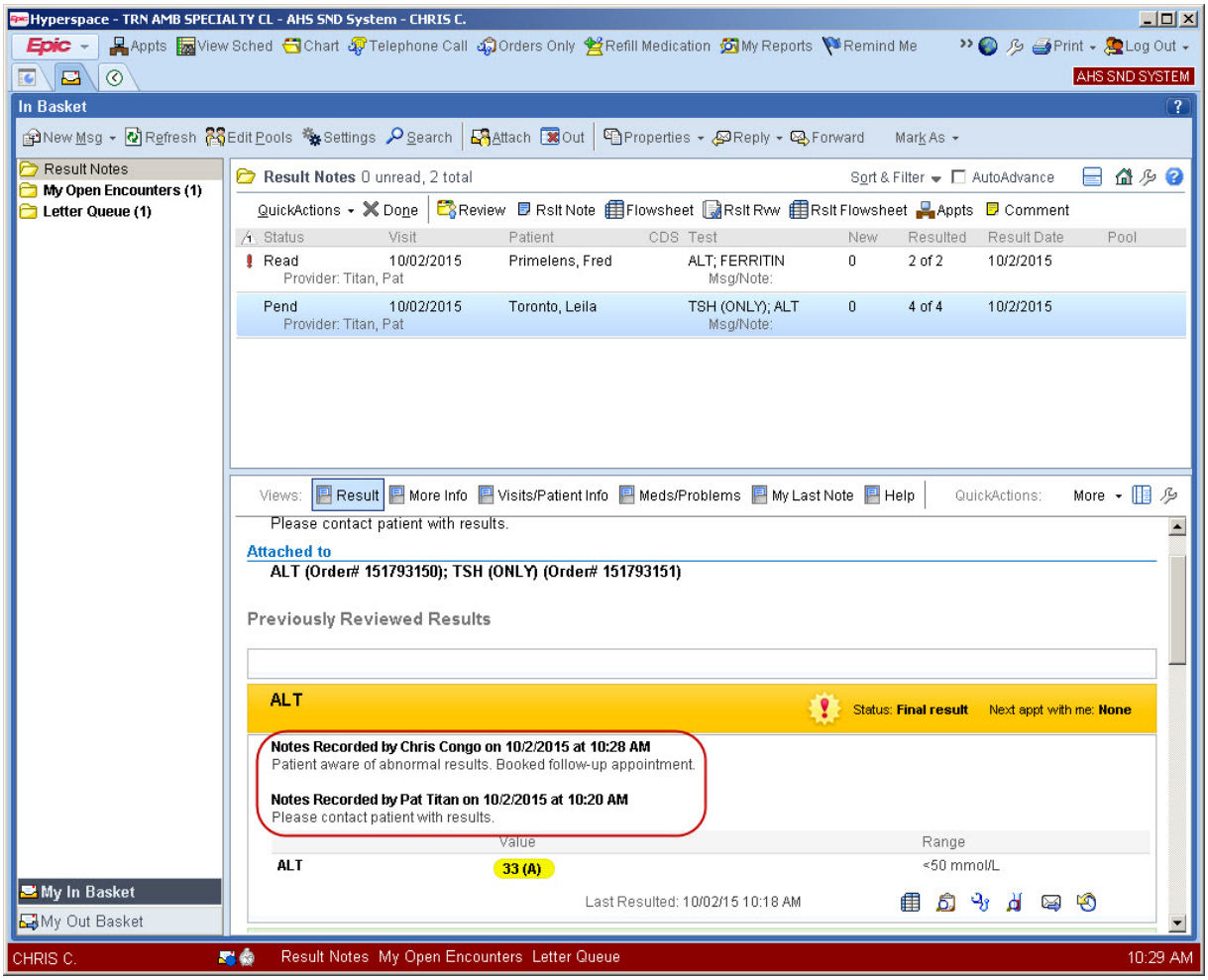
    TIP: Keep the Result Note window open if you have multiple tasks to perform and document.

11. When finished, mark your message as ***Done***.

VIEW RESULT NOTES IN THE PATIENT'S CHART

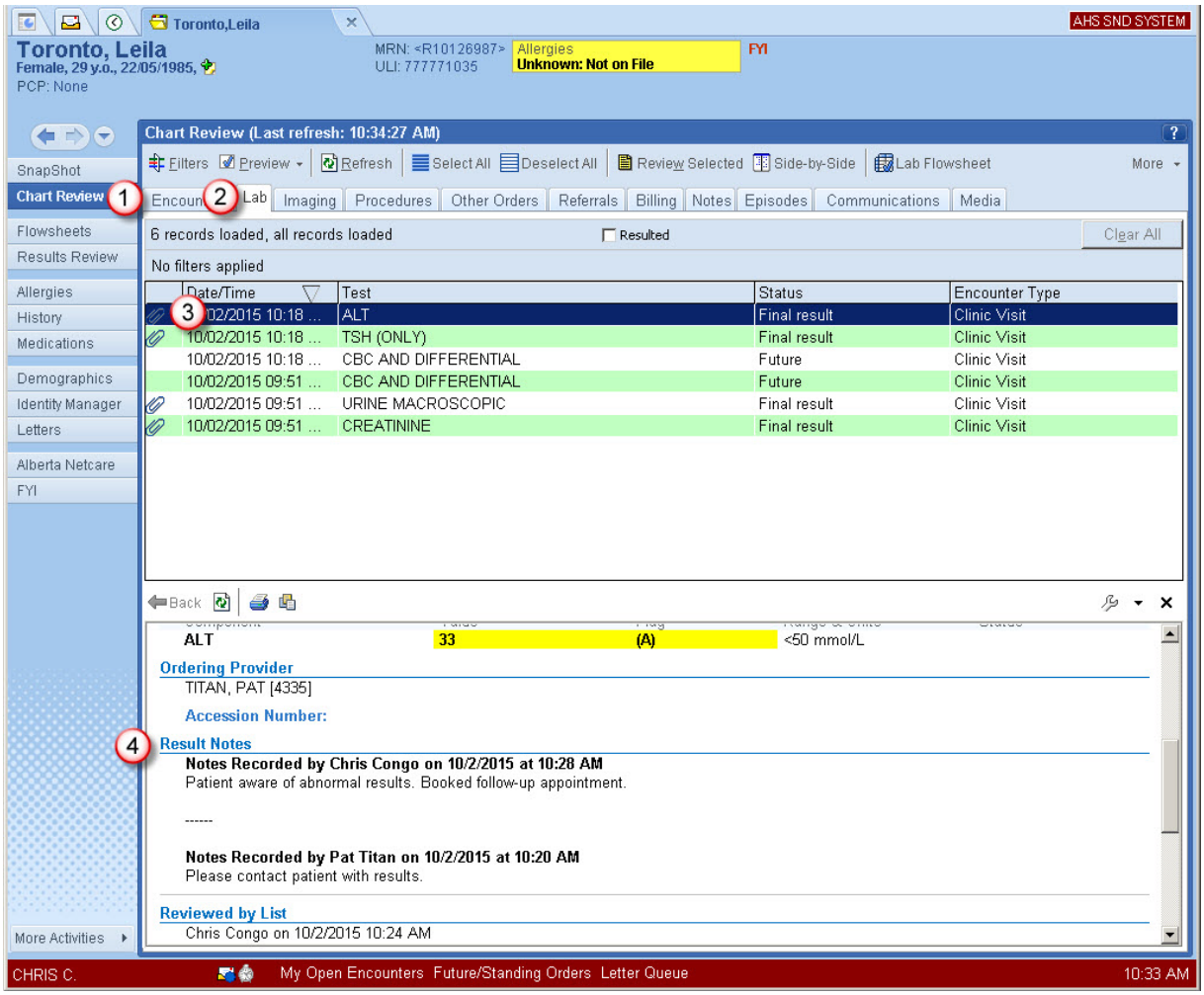
If the Result message is still in your In Basket, Result Notes can be viewed in the Message report (lower) pane.

TIP: Depending on the timing, you may need to manually refresh the system before the result notes display in the Message Report.



All Result Notes related to a result are attached to the result itself and can be seen in the Chart Review activity under the appropriate tab (i.e. Lab, Imaging).

1. Access the Chart Review activity for your patient.
2. Go to the appropriate tab. A list of result records displays. To the left of some records, there is a blue paper clip icon which denotes an attached note.
3. To view the Result (order) report, in the bottom pane, click the appropriate record. Alternately, **double-click** the record to see the report in an expanded form.
4. Scroll through the report until you see the Result Notes section. All associated result notes display below this heading.



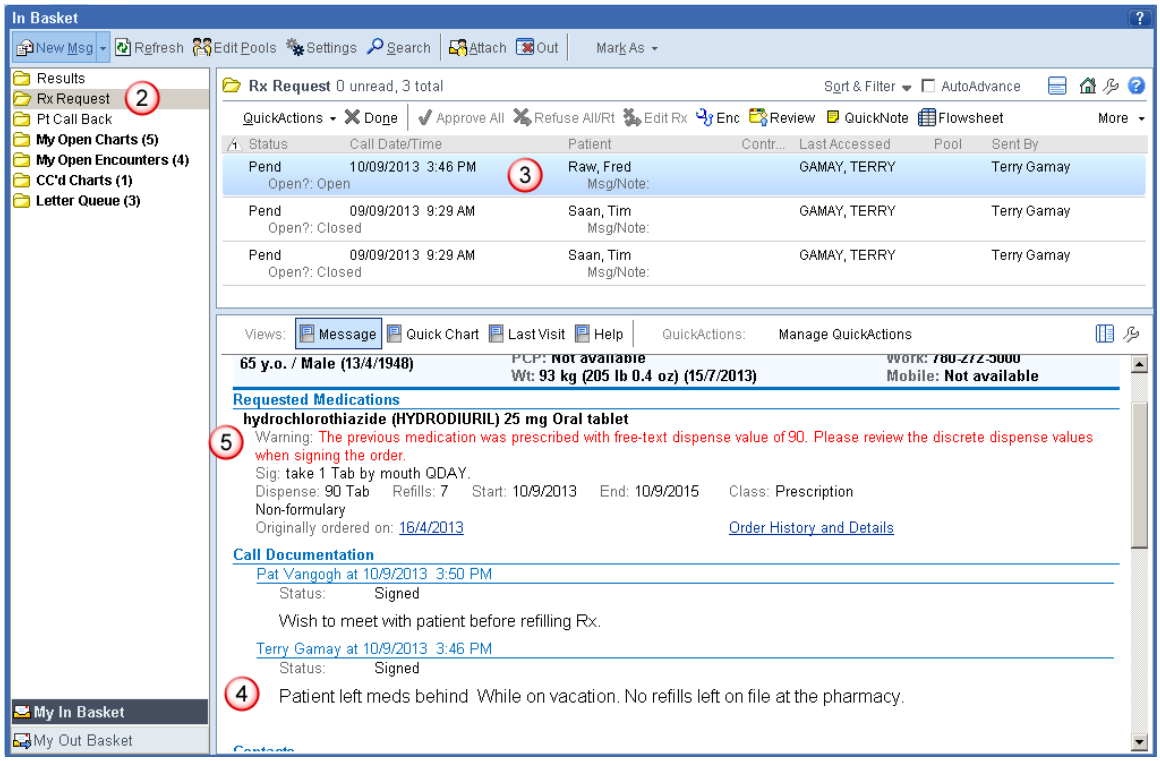
WORK WITH REFILL REQUESTS

When a patient calls or when a fax is received at your clinic requesting a medication refill, the request is documented as a Refill encounter. The Refill encounter is routed to the physician for approval via an Rx Request In Basket message. The approved or denied medication refill request is then routed back to support staff as an Rx Response message.

REVIEW RX REQUEST MESSAGES

Rx Requests placed by your support staff are sent to you via your In Basket and appear in the Rx Request folder.

1. Access the In Basket activity.
2. Select the Rx Request folder.
3. In the Message List (upper) pane, select the message.
4. In the Message Display (lower) pane, review the message details.
5. Take note of any warning messages, which display with red font, included in the message.



APPROVE AN RX REQUEST MESSAGE WITHOUT EDITS

To approve the request with changes, proceed to the next topic ***Approve an Rx Request with Edits***.

To approve the request without making any changes, from the Bottom In Basket toolbar, click **Approve Rx.** This triggers the following actions:

- The Refill encounter is automatically closed.
- The status of the Rx Request message changes to ***Done***.
- The patient sig prints to the designated printer.
- Your approval is automatically sent back to support staff as an Rx Response message.

APPROVE AN RX REQUEST WITH EDITS

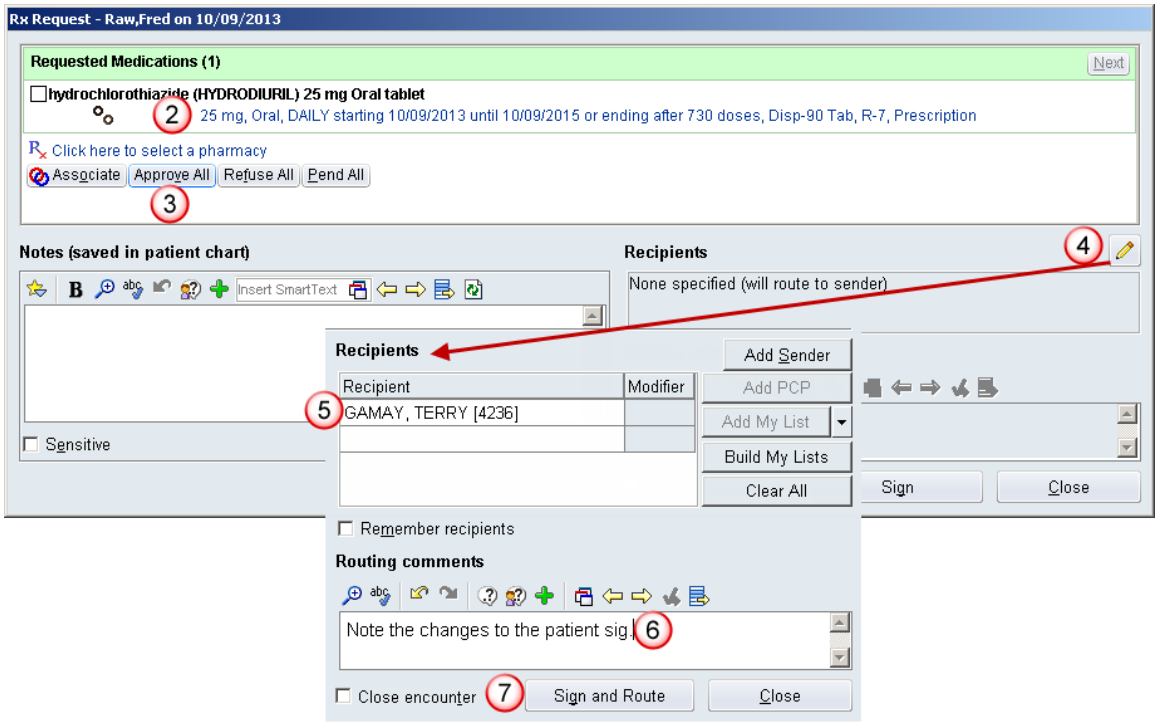
To approve the request without changes, go to the previous topic ***Approve an Rx Request Message without Edits***.

To edit medication details before approving:

1. From the Bottom In Basket toolbar, click **Edit Rx**. The Rx Request window displays.
2. Click the medication hyperlink to open the Order Composer. Make the desired changes and click **Accept**.
3. Select the checkbox beside the medications you wish to approve. Alternately, if there is only one medication, or if you wish to approve all of them, click **Approve All**.
4. If you do not wish to route this message, skip to step 7. To route this message, to the right of the Recipients heading, click the pencil icon.
5. In the **Recipient** field, type a name in the format of ***lastname, firstname*** or enter a pool name.

   TIP 1: If the recipient is the same as the sender of the original request, click **Add Sender** which automatically populates the **Recipient** field for you.

6. In the Routing Comments box, type any follow-up instructions or comments for the recipient.
7. Click **Sign** (if not routing) or **Sign and Route** (if routing).



The In Basket activity redisplays showing the message with a status of ***Done***. Your approval is sent to the recipient(s) as an Rx Response message.

TIP 2: You can return to the original Refill encounter by clicking **Enc** on the Bottom In Basket toolbar.

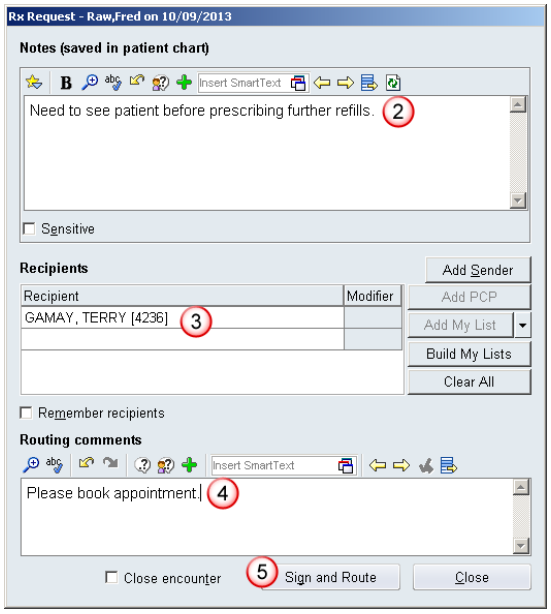
REFUSE AN RX REQUEST

1. From the Bottom In Basket toolbar, click **Refuse All/Rt**. An Rx Request form displays.
2. In the Notes box, enter any information you want documented in the patient's chart.
3. If no follow-up is required, Skip to step 5. To assign any follow-up actions, in the **Recipient** field, type a name in the format of ***lastname, firstname*** or enter a pool name

   TIP: If the recipient is the same as the sender of the original request, click **Add Sender** which automatically populates the **Recipient** field for you.
4. In the Routing Comments box, type any follow-up instructions comments for the recipient.
5. Click **Sign** (if not routing) or **Sign and Route** (if routing). A Refusal Reason window displays.
6. In the **Refusal Reason** field, click the **Selection** tool (magnifying glass) and choose an appropriate refusal reason.

On the bottom right of the Refusal Reason pop-up window, you'll see a button called **My Quick Buttons**. This feature allows you to configure your own buttons for common reasons for visit, which display next to the **Refusal Reason** field in the future.

7. Click **Accept**.

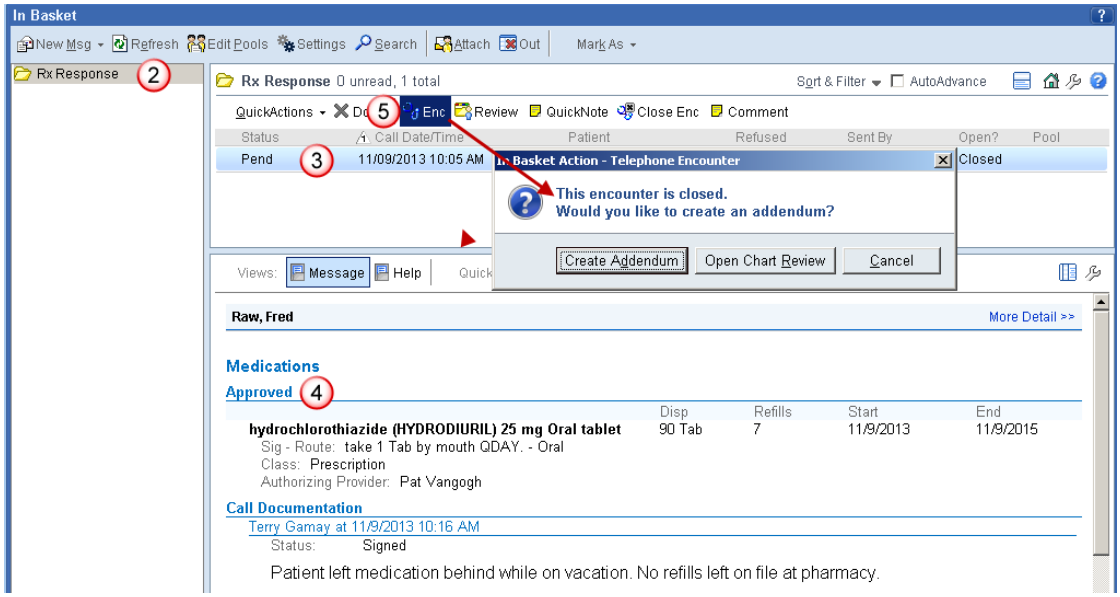


The status of the Rx Request messages changes to ***Done***. Your refusal is sent to the recipient(s) as an ***Rx Response*** message.

PROCESS AN RX RESPONSE MESSAGE

1. Access your In Basket.
2. Select the Rx Response folder.
3. In the Message List (upper) pane, select the message and in the Message Display (lower) pane, read the message.
4. If the prescription has been approved, retrieve the signed form from the designated area.
5. To return to the Refill Encounter to complete documentation, from the Bottom In Basket toolbar, click **Enc**. The patient's workspace displays for the current Refill encounter.

   Note: When Rx requests are approved without changes, the encounter is closed automatically. If you need to return to the encounter, you will need to create an addendum.



6. If contacting the patient about the approval or refusal of the prescription, select the Contacts section and record ***Outgoing*** contact details.
7. If appropriate, select the Documentation section and record any new details.

   TIP: SmartPhrases are a great benefit in this area. Create your own, or use a system SmartPhrase such as .RXFAXED to speed up documentation.
8. From the Refill Encounter Navigator table of contents, click either Close Encounter or Sign/Route Addendum.
9. Return to the In Basket activity and mark the Rx Response message as ***Done***.

Mark In Basket Messages as Done

It is very important that you mark In Basket messages as Done **only after** you have completed the action associated with the message. If you mark the message as Done and are interrupted before you can complete the task, the task might not be completed could have significant impact to patient care.

WORK WITH MESSAGES RELATED TO COMPLETING YOUR CHARTS

You can use your In Basket to keep track of encounters that you haven't yet completed. You can close these encounters from your In Basket with one click. Closing your encounters is necessary because it indicates that all the work pertaining to that particular visit is done.

Best Practice - Importance of Closing your Open Charts and Open Encounters

Similar to the In Patient setting, charts in an enterprise ambulatory EMR must be closed in a timely manner. Encounters with a status of **Open** imply that the information in the encounter is incomplete. As a result, clinicians looking at the encounter details may fail to act on this information.

Users new to ***e*CLINICIAN** often mistakenly open various non-scheduled encounters when that is not their intention. These erroneously opened encounters can be confusing for others viewing the patient's chart.

For both of these reasons, it is critically important that you check your In Basket regularly for **My Open Charts** or **My Open Encounters** messages to verify that there is a clinical reason that the encounter is open.

If you discover that an encounter was opened in error, refer the topic **Correct an Encounter Opened or Charted in Error**.

CLOSE YOUR OPEN CHARTS AND OPEN ENCOUNTERS

The My Open Charts and the My Open Encounters folders contain messages that serve as reminders.

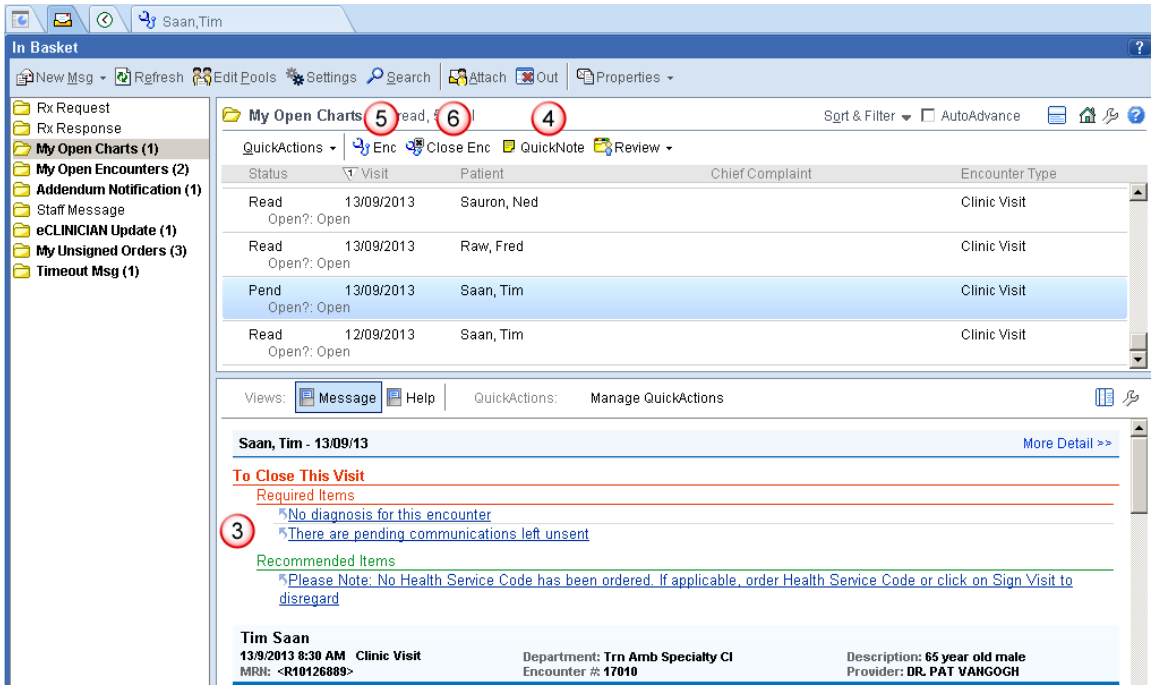
- My Open Charts: This type of message is sent to the In Basket of the scheduled provider, when a scheduled encounter has been open for longer than 24 hours.
- My Open Encounters: This type of message is sent to the In Basket of the user who opened a non-scheduled encounter, as soon as s/he opens it.

You cannot remove either of these message types from your In Basket. The system removes them once the associated encounter is closed.

1. Access the My Open Encounters or My Open Charts folder in your In Basket and select the message you want to review.
2. Review the contents of the message to determine whether the encounter should be closed or whether additional charting is needed.
3. The Message Report identifies any outstanding mandatory requirements and recommended actions using hyperlinks. Clicking these hyperlinks either takes you directly to the area that needs attention, or offers options for next steps.

The Bottom In Basket toolbar contains buttons to help you complete your charting.

4. To add an additional progress note to the chart directly, click **Quick Note**.
5. To finish charting directly in the encounter, click **Enc**.
6. If no further charting is needed, click **Close Enc** to close the encounter and remove the message from your In Basket.



Note: if there are still outstanding requirements you need to fulfill, the system takes you directly to the Close Encounter section of the encounter navigator, and displays warning messages to help you identify and action them.

WORK WITH TELEPHONE-RELATED IN BASKET MESSAGES

There are 3 telephone-related messages you are likely to see in your In Basket.

Pt Call Back - Call Back messages are routed to clinical staff as ***Pt Call Back*** messages. Clinical staff document the return call to the patient using the **Tel Call** button (creates a Telephone Encounter) on the Bottom In Basket toolbar. A prompt to copy the text of the message into the encounter displays.

Patient Call - You receive this message type when a Telephone encounter is routed to you for advice or for you to perform an action.

Phone Calls - Use this message type to send messages to staff regarding a phone call from someone other than a patient. You should not use this message type to send information about patients as there is no way to attach a patient record to the message.

RESPOND TO PT CALL BACK MESSAGES

Call Back messages sent to you by support staff are routed to you as Pt Call Back messages. The receipt of this type of message is typically a prompt to create a Telephone encounter. For details on how to process the Pt Call Back message prior to creating a Telephone encounter, refer to the topic ***Open a Telephone Encounter(Method 3:From a Pt Call Back Message)***.

RESPOND TO PATIENT CALL MESSAGES

Telephone encounters are routed to you for follow-up in the form of Patient Call In Basket messages.

1. Access the In Basket activity.
2. Select the ***Patient Call*** folder.
3. In the Message List (upper) pane, select the message.
4. In the Message Display (lower) pane, review the message details.
5. To add your response directly to the encounter, from the Bottom In Basket toolbar, click **QuickNote**. The QuickNote window displays.

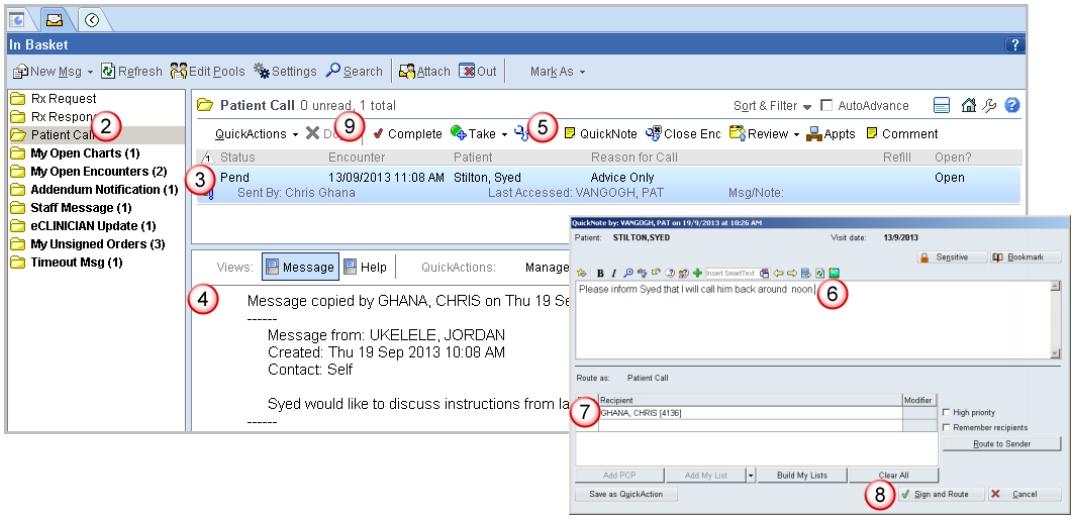
   TIP 1: Note that the **Enc** button on the Bottom In Basket toolbar still allows you to return to the Telephone encounter for the selected Patient Call message.

6. In the QuickNote window, type your response.
7. To route your response back to the sender, enter the name of the recipient or the pool.

   TIP 2: If you are routing this back to the person who sent it to you, beside the Recipient area, click **Route to Sender**.

Notice that on the bottom left of the QuickNote window, there is a **Save as QuickAction** button. QuickActions allow you to complete workflows in fewer steps, saving you time. To learn about creating and managing QuickActions, refer to the Personalization section.

8. Click **Sign** (if not routing) or **Sign and Route** (if routing). Your response is saved to the patient's chart and routed back to the sender. The Message Report redisplays.
9. With your message highlighted in the Message List pane, from the Bottom In Basket toolbar, click **Complete**.



PROCESS LETTER-RELATED IN BASKET MESSAGES

You can create letters from the Communications section of encounter navigators. Where you create letters affects what type of In Basket messages you get and how to manage them.

When clinical staff route letters from an encounter to support staff for processing, the recipient receives a ***Letter Queue*** In Basket message, and the sender a Letter Queue Out Basket message.

When clinical staff route letters from the Letters activity to support staff for processing, the recipient receives a ***Letters*** message, and the sender a Letters-Unsent message.

Recommended Practice!

Due to the robust functionality built into it, we strongly recommend that letter workflows begin in the Communications section of navigators and not the Letters activity.

WORK WITH A LETTER QUEUE MESSAGE – NO EDITS REQUIRED

Use the steps below to complete letter processing in ***e*CLINICIAN** when no additional editing of the letter is required by support staff.

1. Access the In Basket activity.
2. Select the Letter Queue message folder.
3. In the Message List (upper) pane, select the message.
4. In the Message Display (lower) pane, review the letter instructions.
5. From the Bottom In Basket toolbar, click ***Comm Mgt***. The Communication window displays a list of the letter recipients.

If the physician you are sending the letter to is live on ***e*CLINICIAN** AND has the ability to receive letters via their In Basket, the IB (In Basket) option is the default delivery method.

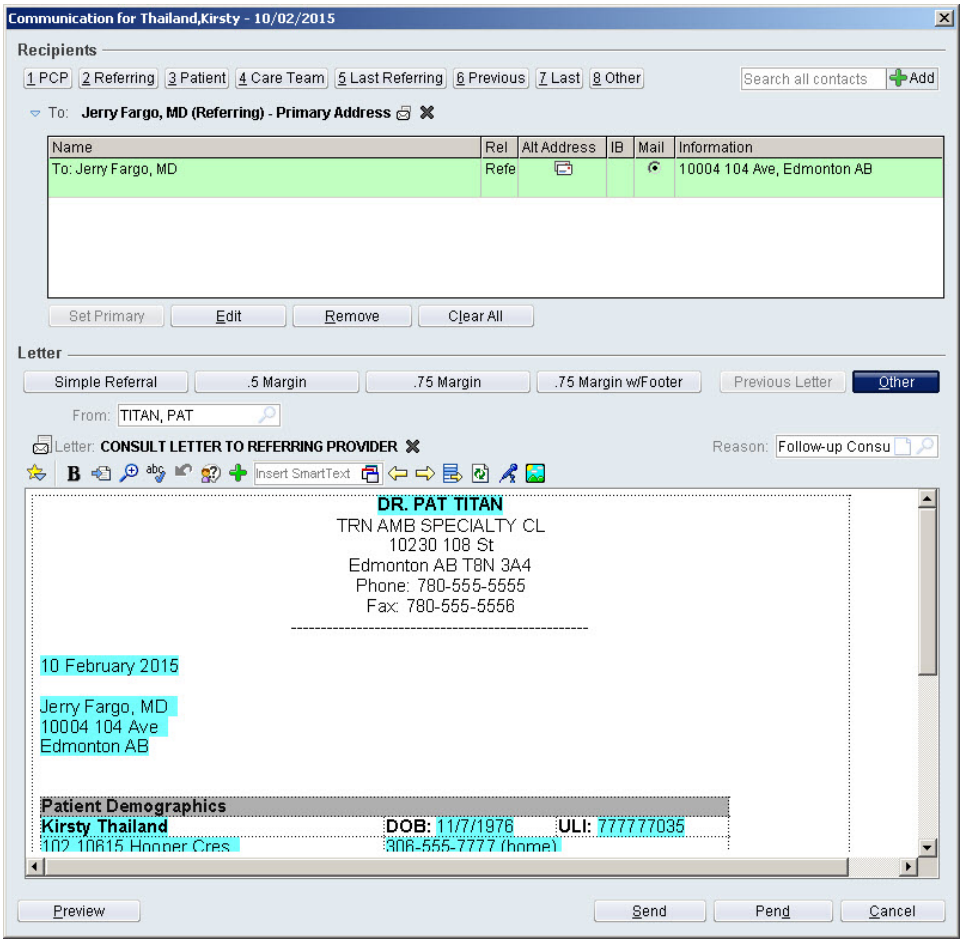
Changing Communication Method

Regardless of whether the recipient is live on *e*CLINICIAN or not, most clinics continue to send letters by mail or fax. This will continue until such time as we can ensure that all physicians are working in their In Baskets as expected.

There are two ways to change the communication method:

Click the recipient's name and from the menu, select Mail.

To the left of the recipient, click the blue arrow and under the Mail column, select the radio button. To collapse the grid, click the blue arrow again.



6. To print the letter and mark it as ***Sent*** in the patient's chart, click Send.

   The In Basket activity redisplays with the Letter Queue message removed from your In Basket.

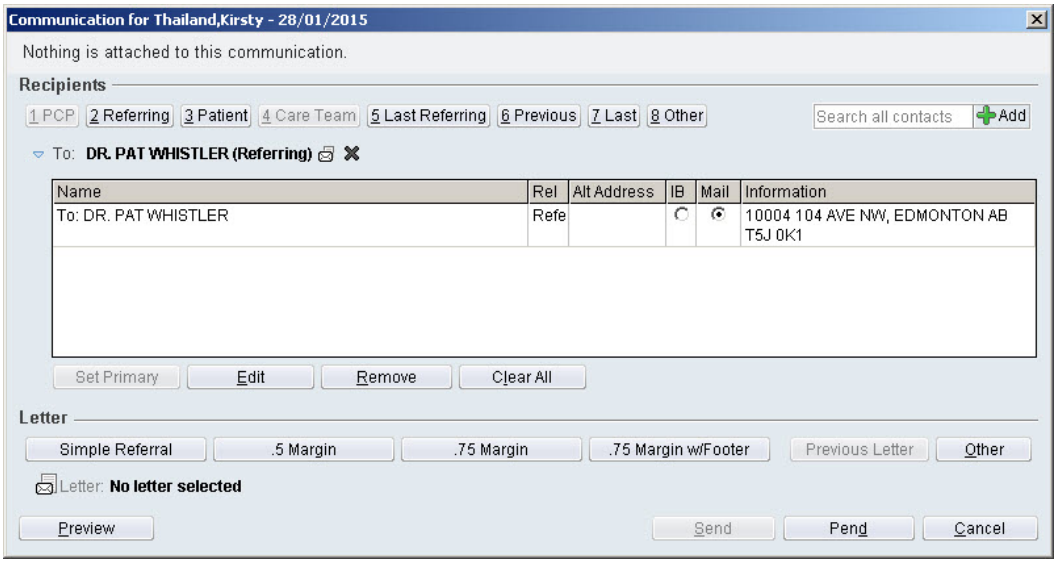
When the letter is marked as ***Sent*** it is no longer available for editing.

7. Send the letter according to your clinic's practice.

WORK WITH A LETTER QUEUE MESSAGE – EDITS REQUIRED

Physicians and support staff can use the steps below to complete letter processing in ***e*CLINICIAN**.

1. Access the In Basket activity.
2. Select the ***Letter Queue*** folder.
3. Select the appropriate message in the message list pane.
4. Review the letter instructions in the message report pane.
5. To edit or review the letter, click **Comm Mgt** from the Folder toolbar. The Communication window displays.
6. From the Communication window, the letter can be modified as necessary. Add or alter the recipient and click the blue arrow next to the recipient to change how the message is being sent (via mail or In Basket).



Changing Communication Method

Regardless of whether the recipient is live on ***e*CLINICIAN** or not, most clinics continue to send letters by mail or fax. This will continue until such time as we can ensure that all physicians are working in their In Baskets as expected.

There are two ways to change the communication method:

Click the recipient's name and from the menu, select Mail.

To the left of the recipient, click the blue arrow and under the Mail column, select the radio button. To collapse the grid, click the blue arrow again.

7. Choose the letter template, if this has not already been selected.

8. Add or alter who the letter is From.
9. Add the body of the letter by typing and/or using SmartText or SmartPhrases.
10. Add a Reason for the letter to assist with sorting letters in Chart Review.

If your process is to have the physician review the letter before sending, proceed to the next topic titled ***Route Letter Back to Physician for Review***.

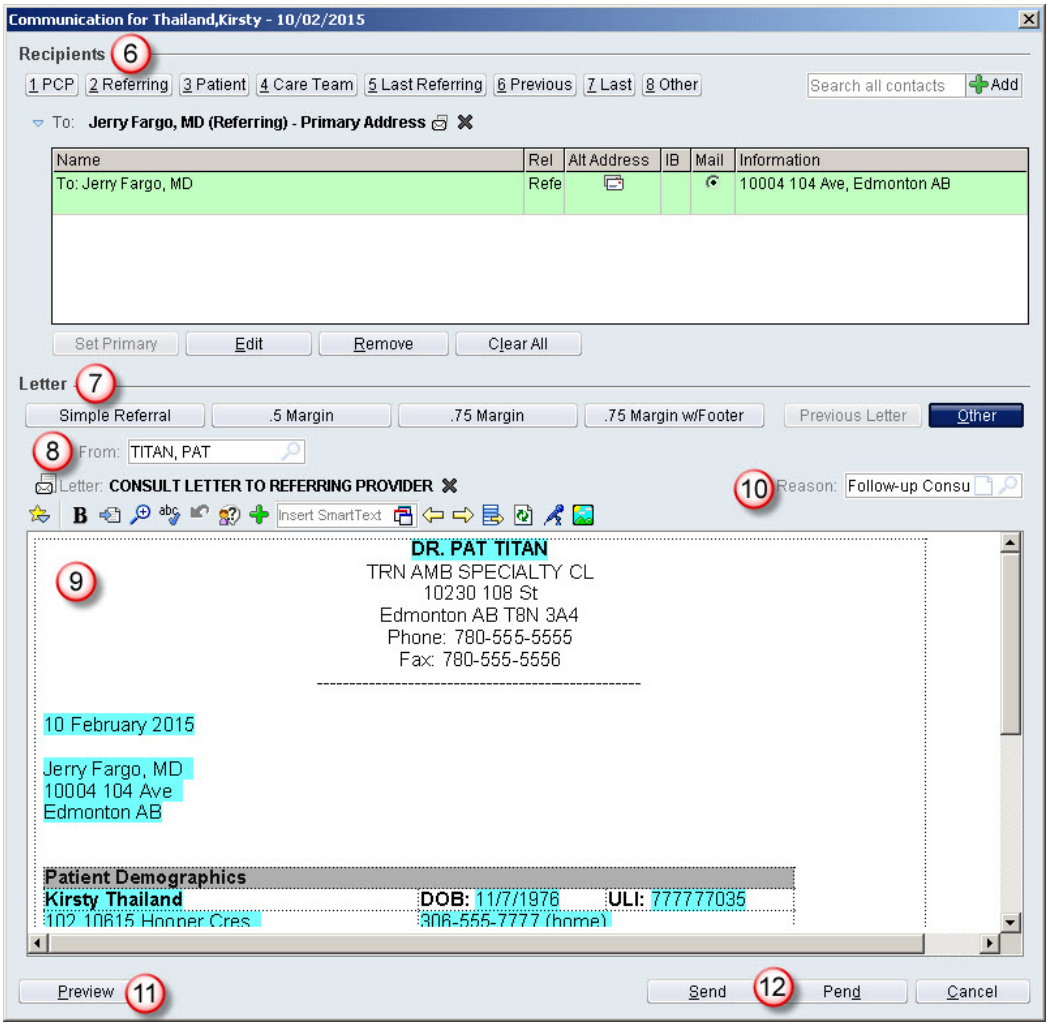
11. To preview the letter prior to sending, click **Preview**. From the Preview window, the letter can be printed for review on paper, if needed.

Printing from the Preview Screen

Printing from the Preview screen will not change the Letter status to ***Sent***.

To Print the finalized letter, it is important to click **Send** from the Communication window.

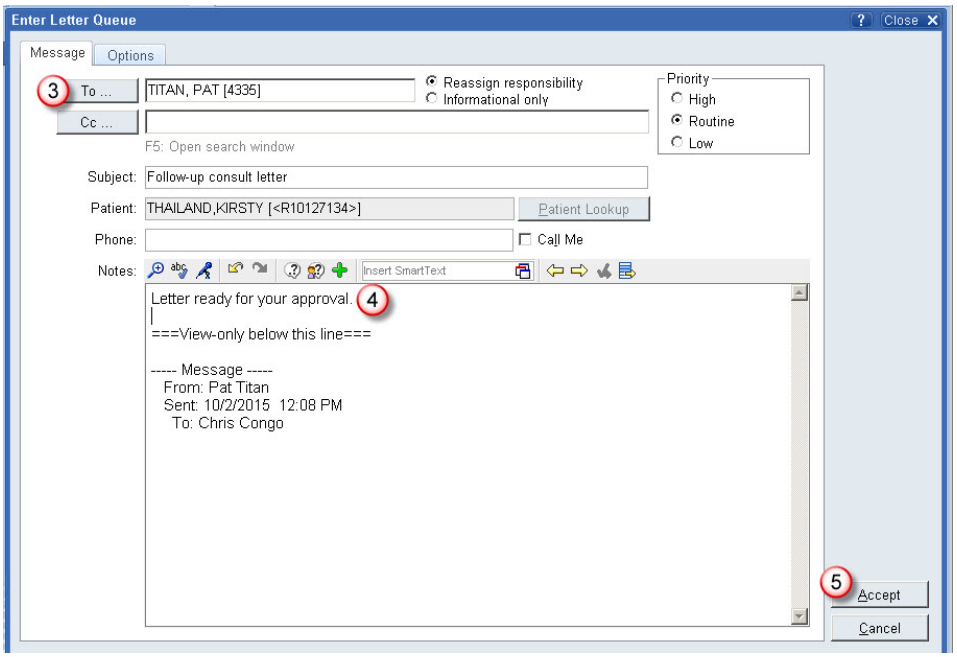
12. When edits are complete, click:
    - **Pend** to save the letter and allow future editing. Unsaved letters may be lost if the system secures after a period of inactivity.
    - **Send** to print the letter or send via the In Basket. This action is irreversible and locks the letter from further editing.The status will be marked as ***Sent*** and the Letter Queue message is removed from the In Basket.
13. The In Basket activity redisplays.



ROUTE LETTER BACK TO PHYSICIAN FOR REVIEW - OPTIONAL

If the physician's preference is to review the edited letter before it is sent, support staff may route it to the physician's In Basket. It is important to note that the physician must Forward the letter back to support staff in order for the letter to be edited, printed or sent.

1. From your In Basket, select the appropriate Letter Queue message.
2. From the Top In Basket toolbar, click **Forward**. The Enter Letter Queue window displays.
3. Enter the physician's name in the ***last name, first name*** format.
4. Type your comments for the physician.
5. Click **Accept**. The In Basket activity redisplays and your Letter Queue message is no longer visible.

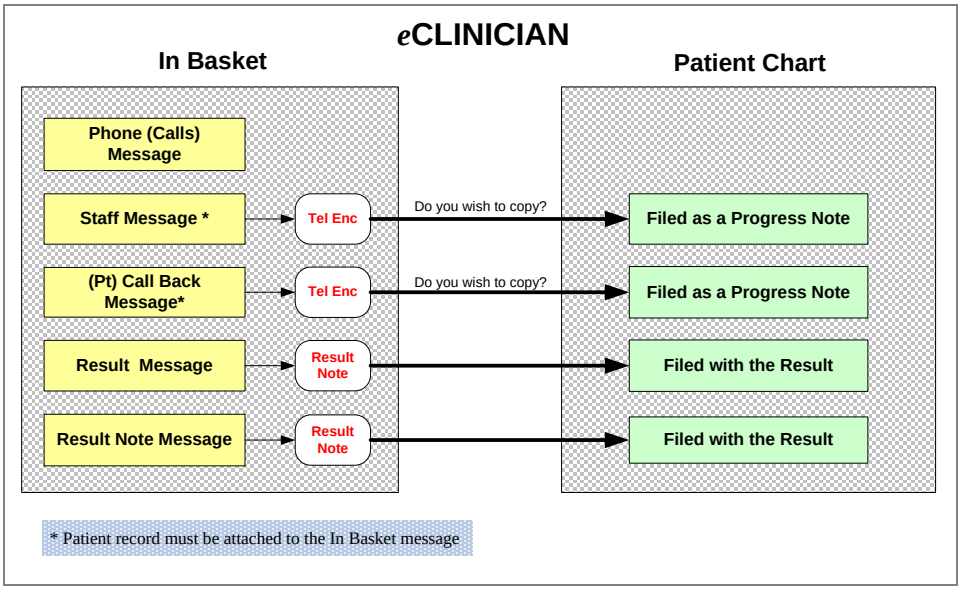


When you return the letter for review, the physician receives a Letter Queue message. The physician must also follow the steps listed above to add their review comments and forward the Letter Queue message back.

IN BASKET MESSAGES AS PART OF THE CLINICAL RECORD

When responding to messages in your In Basket, you must consider whether or not the response should be part of the clinical record for that patient.

The following diagram illustrates how some In Basket message types are designed to work with specific toolbar buttons that copy the information from the In Basket message to patient's chart (clinical record).



The following message types originate from an encounter and are already part of the patient's chart.

- ***Patient Call***, created from a Telephone Encounter
- ***Rx Request***, created from a Refill Encounter
- ***CC'd Chart***, created from the Follow-up section of an encounter

Use the **QuickNote** button on the Top In Basket toolbar to file the information to the patient's chart.

If you determine that information contained in another message type needs to become part of the patient's clinical record, and **QuickNote** isn't available, follow these steps:

1. Find the appropriate encounter or create a new encounter.
2. Manually copy the text of the In Basket message.
3. From the navigator table of contents, access either the Progress Notes or the Documentation section.
4. Paste the copied text in the text window.

If no further action is required, from the navigator table of contents, click Close Encounter or Sign/Route Addendum.

DOCUMENT NON SCHEDULED ENCOUNTERS

Non scheduled encounters represent documentation that you create when the patient is not physically with you. Examples of non scheduled encounters include: Telephone, Refill, Letters and Orders Only.

The following main topics are covered in this chapter:

- Create an Orders Only Encounter
- Document a Telephone Encounter
- Document a Refill Encounter

CREATE AN ORDERS ONLY ENCOUNTER

Use an Orders Only encounter to document any of the following:

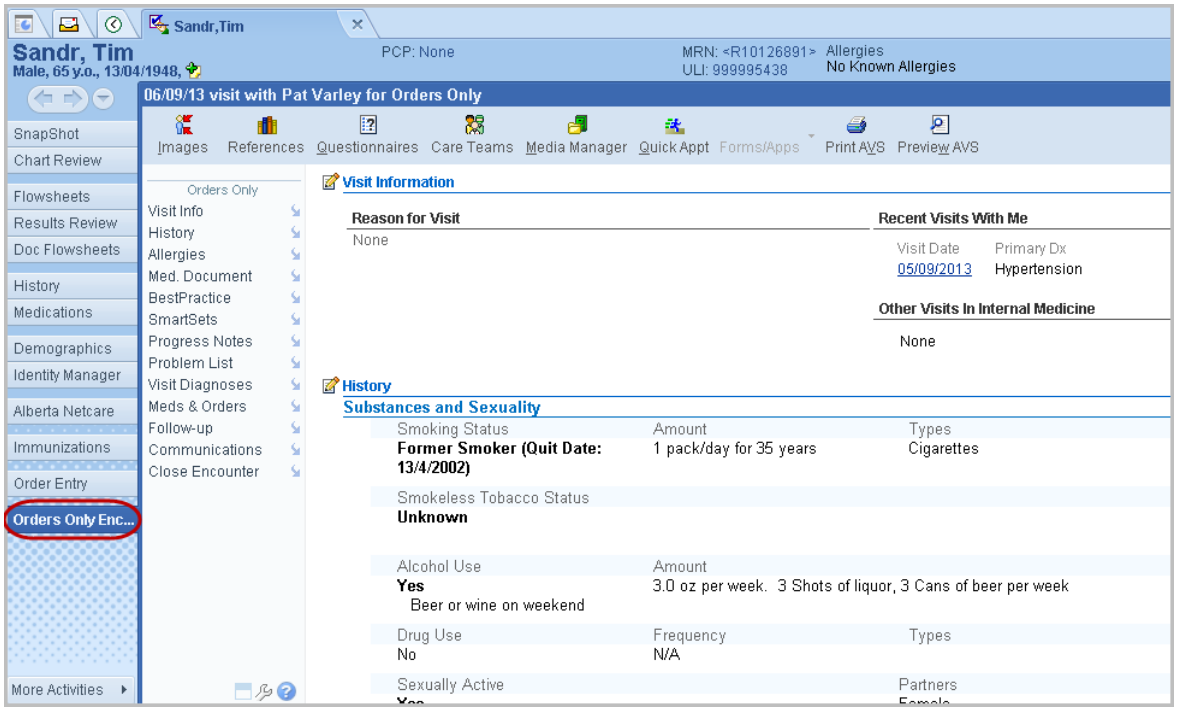
- Additional patient information that is not related to a past encounter.
- Orders placed prior to a patient visit.
- Additional orders placed after a patient visit when the encounter is closed.

Basically, an Orders Only encounter is used to document additional information about a patient who you are not scheduled to see. Think of it as a ***miscellaneous*** encounter.

DOCUMENT AN ORDERS ONLY ENCOUNTER

METHOD 1: FROM THE HYPERSPACE TOOLBAR

1. To open an Orders Only encounter, use one of the following methods:
   A. From the Hyperspace (main) toolbar, click **Orders Only**.
   B. From the **Epic** button, select **Patient Care > Orders Only**.
2. From the Patient Lookup window, search for the patient according to your clinic's practice. The Orders Only Encounter navigator displays.



My Open Encounters In Basket Folder

***e*CLINICIAN** sends a My Open Encounters In Basket message to your In Basket when you open an Orders Only encounter.

My Open Encounters messages allow you to track which Orders Only encounters are still outstanding.

You work with the sections of the Orders Only Encounter navigator the same way that you worked with the sections of the Visit Navigator for office or clinic visits.

3. Document the appropriate information in the corresponding navigator sections. The only requirement to close an Orders Only encounter is to sign any orders placed.
4. When you are done, close the encounter.

DOCUMENT A TELEPHONE ENCOUNTER

Use a Telephone encounter to document a phone call from a patient about a medical inquiry or medical advice. You will also use a Telephone encounter to document a call related to a clinical matter about a patient.

OPEN A TELEPHONE ENCOUNTER

METHOD 1: FROM THE HYPERSPACE TOOLBAR

1. From the Hyperspace (main) toolbar, click **Telephone Call**. The Patient Lookup window displays.
2. Look up the patient according to your clinic's practice. The patient's workspace displays.

METHOD 2: FROM THE EPIC BUTTON

1. From the Epic button, select Patient Care > Telephone Call. The Patient Lookup window displays.
2. Look up the patient according to your clinic's practice. The patient's workspace displays.

METHOD 3: FROM A PT CALL BACK MESSAGE

When patients call with a medical inquiry, it may be your practice to have support staff create a Call Back In Basket message rather than directly opening a Telephone encounter to document the request. Call Back messages are routed to clinical staff as Pt Call Back messages.

1. Access your In Basket.
2. Select the Pt Call Back folder.
3. Highlight the message in the upper right-hand pane.
4. Review the letter instructions in the lower right-hand pane.

5. From the Bottom In Basket toolbar, click **Tel Call**. A message displays asking if you want to copy the text from the message to the encounter notes.
6. To copy the text of the message to the Telephone encounter (and be part of the clinical record), click **Yes**.

DOCUMENT A TELEPHONE ENCOUNTER

You work with the sections of the Telephone Call navigator the same way that you worked with the sections of the Visit Navigator for office or clinic visits.

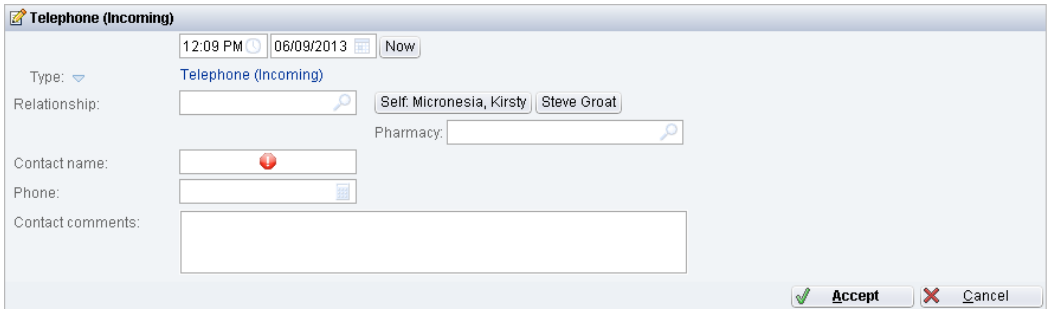
My Open Encounters In Basket Folder

***e*CLINICIAN** sends a My Open Encounters In Basket message to your In Basket when you open a Telephone encounter.

My Open Encounters messages allow you to track which telephone calls are still outstanding.

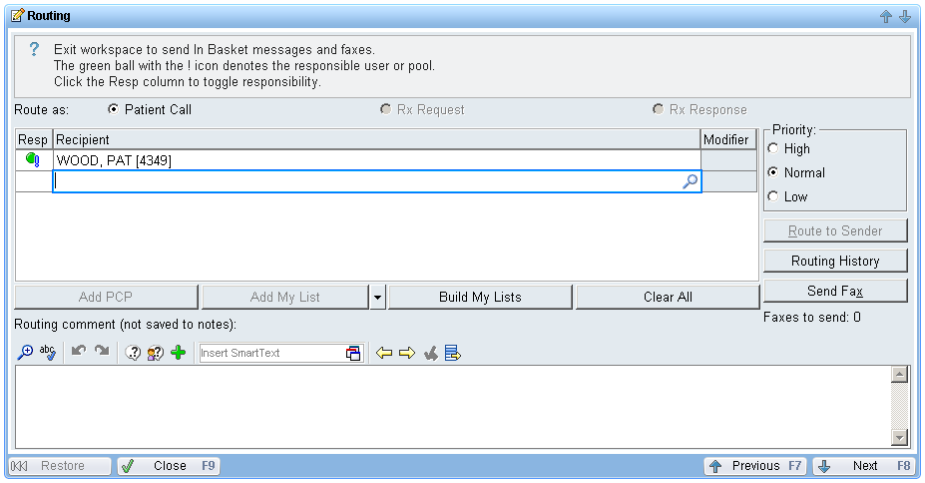
My Open Encounters messages are sent to the In Basket of the person who initiated the encounter. If your front desk staff initiates a telephone encounter instead of sending a Pt Call Back message to clinical staff, they will receive the My Open Encounters message.

1. From the Telephone Call navigator, select Incoming Call. The Telephone (Incoming) window displays in edit mode.



2. Indicate who is calling and their contact information.
3. Click **Accept**. The Contacts section closes.
4. Click on the Reason for Call section. The Reason for Call window appears. In the **Reason for Call** field, completion match on the appropriate reason.
5. From the navigator table of contents, select the Documentation section and record the details of your conversation with the patient.
6. Complete remaining documentation as required.
7. If you do not need to route the Telephone Encounter to someone for advice, proceed to step 8.

   To route the encounter, select the Routing section of the navigator.



Notice that the ***Patient Call*** option is selected by default within Telephone encounters.

A. In the **Recipient** field, completion match on the name of the recipient.

B. Close the Routing section.

C. Exit the patient's workspace to route your message.

Remember that exiting the patient's workspace is not the same as closing the encounter. If you exit a workspace without closing the encounter, you can easily return to the workspace again.

8. If you do not need to route the message and your documentation of the call is complete, from the Navigator table of contents, select Close Encounter. The only requirement for closing a Telephone encounter is a Reason for Call.

When to Close a Telephone Encounter

The Telephone encounter should remain open as long as you are still dealing with the reason for the call.

Since Telephone encounters may be routed back and forth between clinical staff, it is often difficult to know when the encounter is complete and may be closed. You can use the Last Accessed column in the In Basket to keep track of who has accessed the Telephone encounter.

It is the responsibility of the person who created the encounter to close the encounter.

DOCUMENT A REFILL REQUEST

Use a Refill encounter to document a call from a patient requesting a medication refill. This encounter type is also used to document faxed medication refill requests from pharmacies.

OPEN A REFILL ENCOUNTER

METHOD 1: FROM THE HYPERSPACE TOOLBAR

1. From the Hyperspace (main) toolbar, click Refill Medication. The Patient Lookup window displays.
2. Look up the patient according to your clinic's practice. The patient's workspace displays.

METHOD 2: FROM THE EPIC BUTTON

1. From the Epic button, select Patient Care > Refill Medication. The Patient Lookup window displays.
2. Look up the patient according to your clinic's practice. The patient's workspace displays.

DOCUMENT A REFILL ENCOUNTER

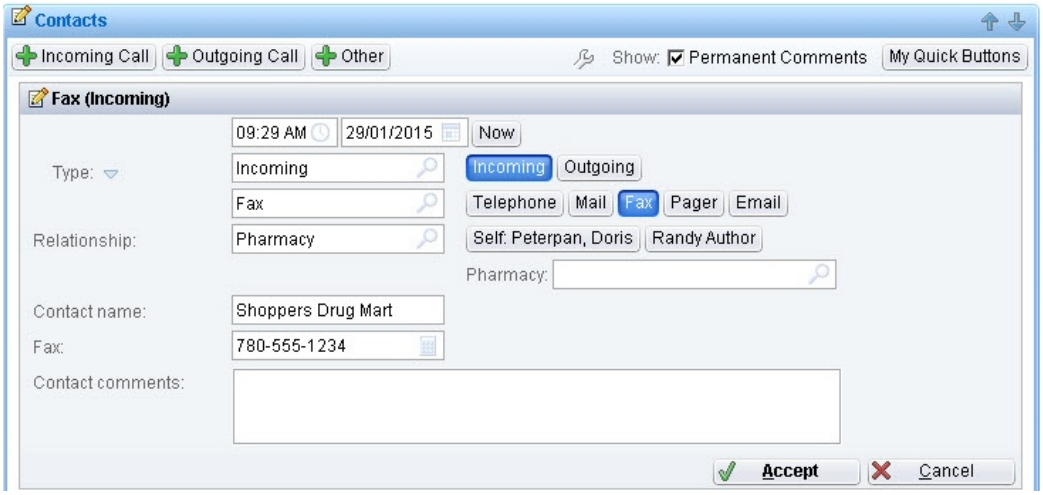
You work with the sections of the Refill Encounter navigator the same way that you worked with the sections of the Visit Navigator for office or clinic visits.

My Open Encounters In Basket Folder

***e*CLINICIAN** sends a My Open Encounters In Basket message to your In Basket when you open a Refill encounter.

My Open Encounters messages allow you to track which Refill encounters are still outstanding.

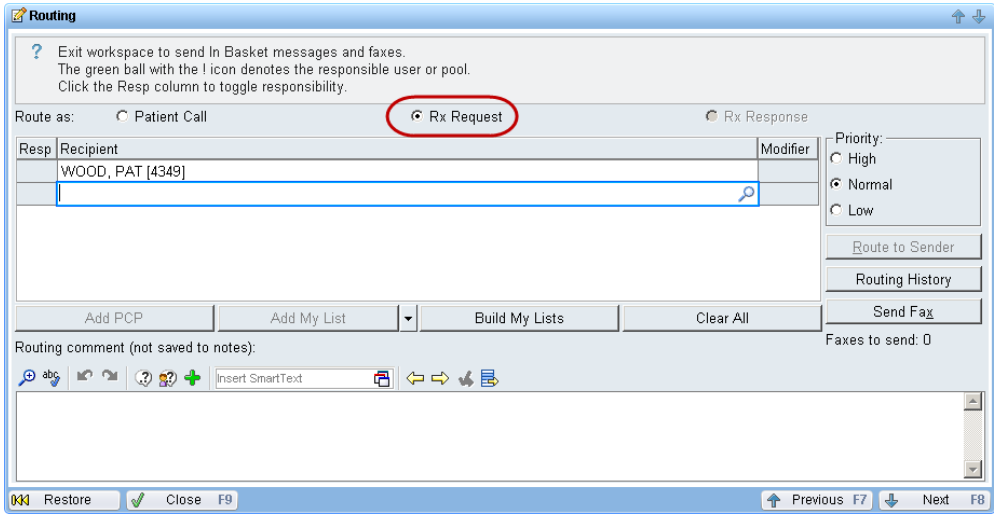
1. From the Refill Encounter Navigator table of contents, select Incoming Call for telephone requests. For fax or email requests, select Other and indicate Incoming. The Contacts section displays in edit mode.
2. For phoned request, indicate who is calling and their contact information. For fax/email requests indicate the following:
    A. In the **Relation** field, completion match on ***Pharmacy***.
    B. In the **Contact** field, type the name of the pharmacy.
    C. In the **Fax** field, type the fax number of the pharmacy.
    D. Add any other pertinent pharmacy information to the **Comments** field.



3. Click **Accept**.

The Reason for Call section has been pre-populated with ***Medications Refill***.

4. From the table of contents, select Documentation and add information about the refill request.
5. From the table of contents, select Meds & Orders.
6. Click **Reorder** next to the appropriate medication(s).
7. Close the section.
8. From the table of contents, select Routing. The ***Rx Request*** option is selected by default because Medications Refill is the reason for call for this encounter.



9. In the **Recipient** field, type the name of the person who will receive the Rx Request In Basket message.
10. Close the section.

TIP: Always verify the name of the intended recipient(s) when you close the Routing section. If you accidently select the wrong recipient or fail to add the recipient correctly, a message will be routed to the wrong recipient or never be routed. This could lead to a significant delay in patient care.

11. To route the message to the intended recipient, exit the patient's workspace.

Remember that exiting the patient's workspace is not the same as closing the encounter. If you exit a workspace without closing the encounter, you can easily return to the workspace again.

PERSONALIZE *e*CLINICIAN

e*CLINICIAN - EMR** provides you with many opportunities to customize or ***personalize the system to meet your needs and preferences. Taking the time to customize the application can save you time later by reducing the number of steps it takes to accomplish common tasks.

The following main topics are covered in this chapter:

- Personalize Navigation and Activities
- Create Patient Lists
- Create a Custom Dictionary
- Personalize Features of the Visit Navigator
- Personalize Features of the Chart Review Activity
- Manage Personal Preference Lists Outside of an Encounter
- Manage Personal SmartPhrases
- Manage SmartBlock Macros
- Customize the In Basket

PERSONALIZE NAVIGATION AND THE APPEARANCE OF VARIOUS ACTIVITIES

***e*CLINICIAN - EMR** provides you with the opportunity to create navigational shortcuts to activities that you access most frequently. You also have the ability to customize the appearance of your daily schedule and change the way that information displays in some activities and navigator sections.

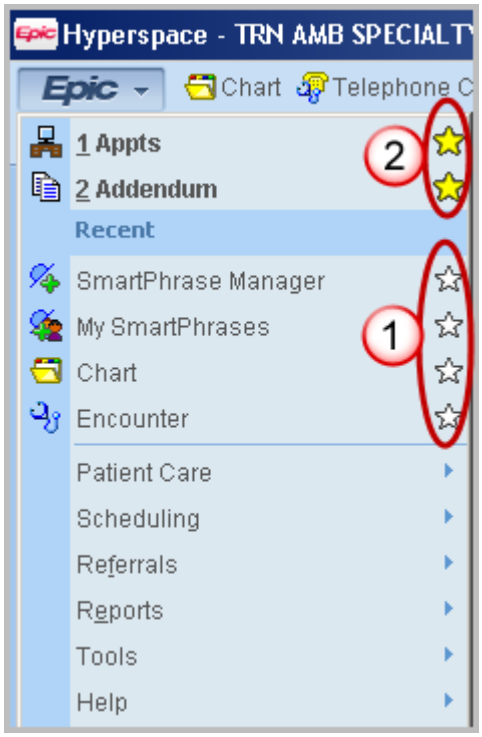
PERSONALIZE THE EPIC BUTTON

The features that you access most commonly typically display as buttons on the Hyperspace (main) toolbar. Your security role determines these primary features.

The secondary features that you can access are available from the **Epic** button menu. To provide you with quick navigation to these items in the future, you can mark them as being a ***favorite***.

① If one of the Recent items you accessed from the **Epic** button represents an item that you access regularly, click the star next to the item to mark it as a favorite.

② Favorites display at the top of the Epic menu for convenient access. To quickly access a specific favorite, press **ALT** to launch the Epic menu, and then press the number that corresponds to your favorite. In the screenshot above, pressing **ALT+2** opens the Patient Lookup window to search for a patient's chart to addend.

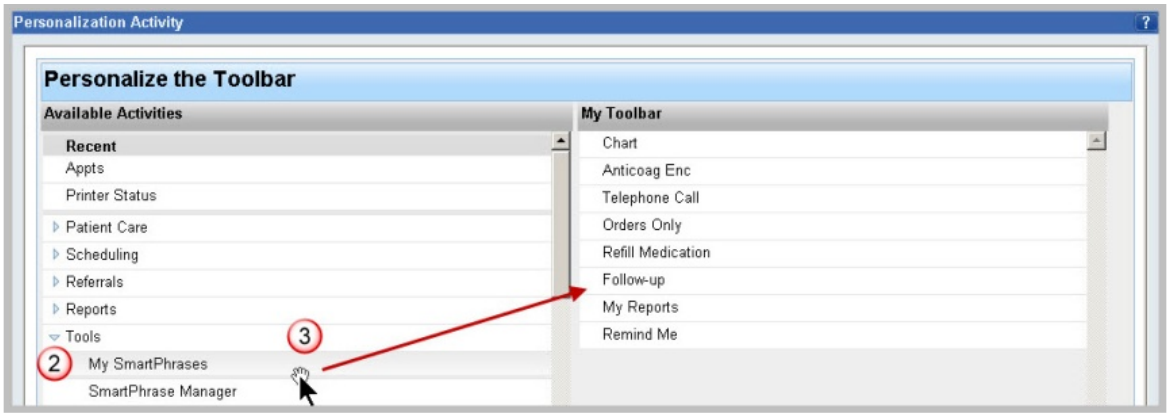


PERSONALIZE THE HYPERSPACE TOOLBAR

You can personalize your Hyperspace toolbar with activities you frequently use. The activities you can add are based on your security role.

1. From the Hyperspace toolbar, click the wrench.

2. Locate the button you wish to add (e.g. **My SmartPhrases**).
3. Click and drag the item to the My Toolbar section on the right.

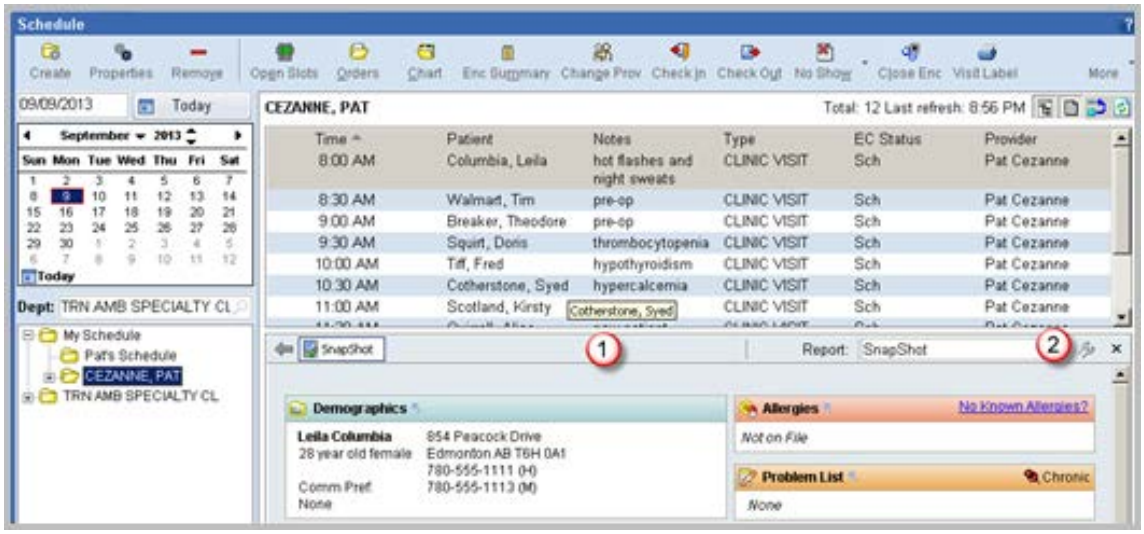


4. Reorder items in the My Toolbar list by dragging them up or down to a new location.
5. Click **Accept**. The new button appears on the Hyperspace toolbar.
6. If you cannot see all the buttons you have added, click the double chevrons (>>) to see the additional buttons.

ADD ADDITIONAL REPORTS TO THE SCHEDULE ACTIVITY

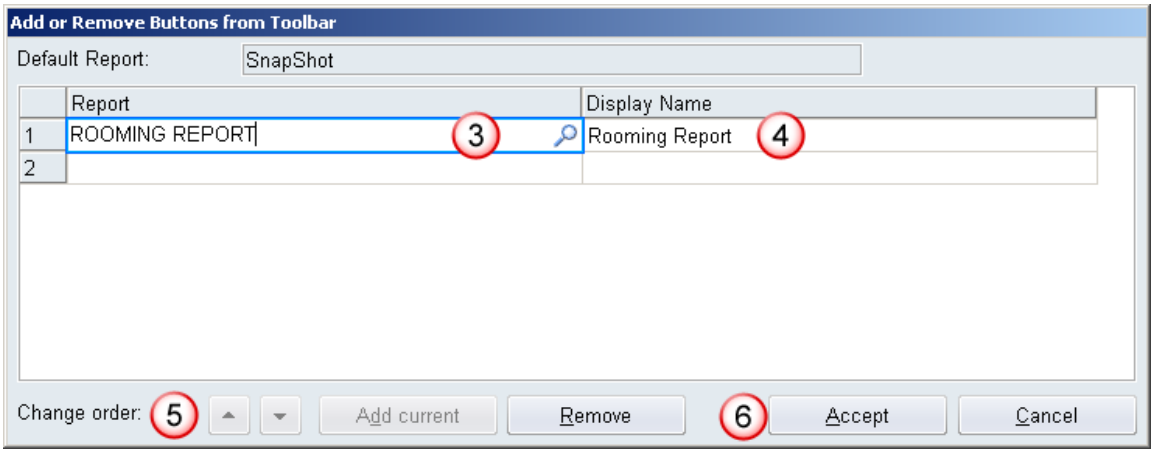
The SnapShot report is the default report on the Schedule activity. You can quickly personalize this area so that other reports are easily accessible.

1. In the Schedule activity, access the Reports toolbar.
2. Click **Add or remove buttons from toolbar** (the wrench).

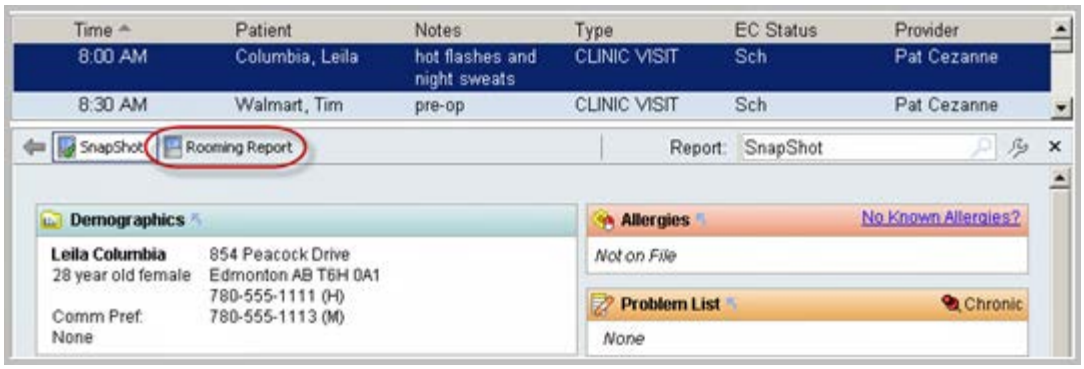


The Add or Remove Buttons from Toolbar window displays

3. Use completion matching or click the **Selection** tool (magnifying glass) to locate the report you want to add.
4. If appropriate, change the **Display Name** for each report.
5. If adding multiple reports, use the Up and Down arrows to change the order that the reports display on the Reports toolbar.
6. When you are done, click **Accept**.



The appropriate report displays on the Reports toolbar. Note that the **Report** field on the Report toolbar is used to temporarily display one of the available reports.



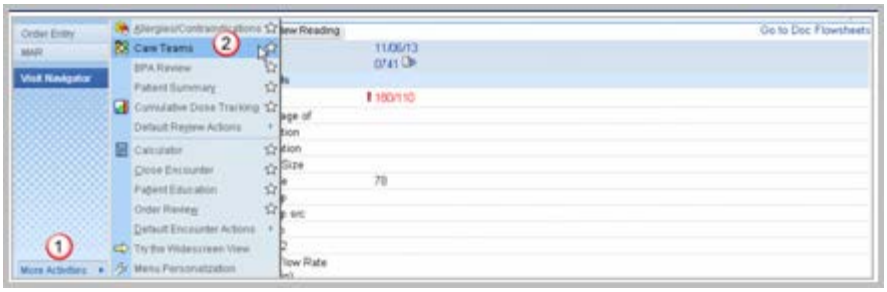
TIP: We recommend adding the Care Teams & Notes report next to the Snapshot report.

PERSONALIZE ACTIVITY TABS

ADD ACTIVITY TABS TO THE ACTIVITY TAB LIST BY MARKING IT AS A FAVORITE

You can customize your Activity tabs to include additional options and provide easy access to the activities you use most.

1. From the Visit Navigator, select More Activities. A menu displays a list of additional activities.
2. Next to the activity you wish to save as a favorite, click the white star. The white star turns to yellow and your selected activity appears on your list of activities.



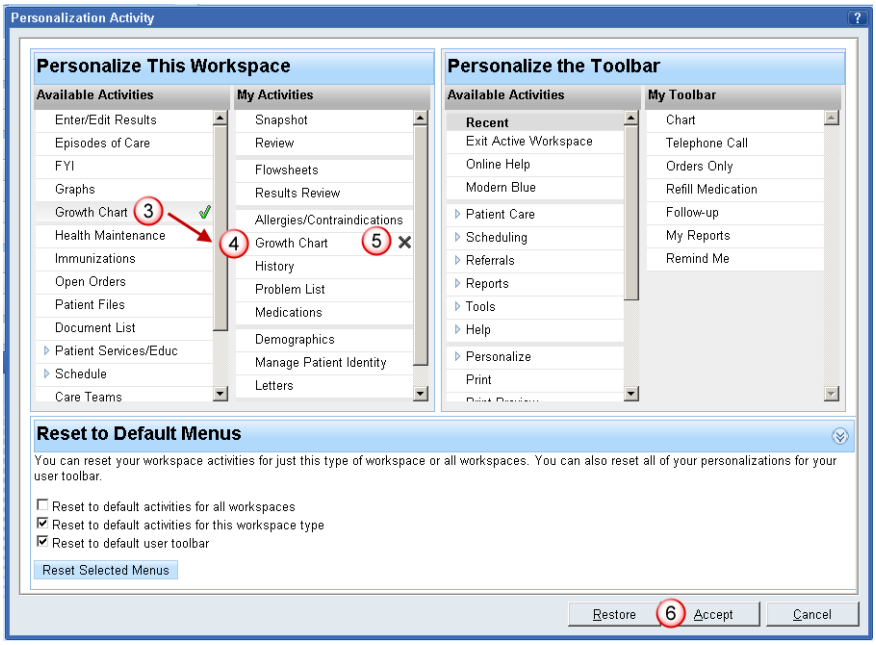
ADD ACTIVITY TABS TO THE ACTIVITY TAB LIST USING THE PERSONALIZATION ACTIVITY

Additional options and the ability to re-order the list of activities are available from the Menu Personalization activity.

1. From the Visit Navigator, select More Activities. A menu displays a list of additional activities.
2. In More Activities, select Menu Personalization.

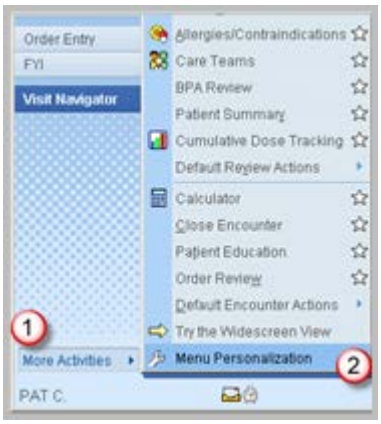
The Personalization Activity displays with two panes: Personalize This Workspace and Personalize This Toolbar.

3. From the Personalize This Workspace pane, in the Available Activities section, select an activity.
4. Drag it to the My Activities section. A green checkmark appears next to the activity you chose, showing it was added.
5. Click the black **X** to remove an activity that you have added.
6. Click **Accept** to save your changes.



CHANGE THE ORDER OF ACTIVITY TABS

1. From the Visit Navigator, select More Activities. A menu displays a list of additional activities.
2. In More Activities, select Menu Personalization.



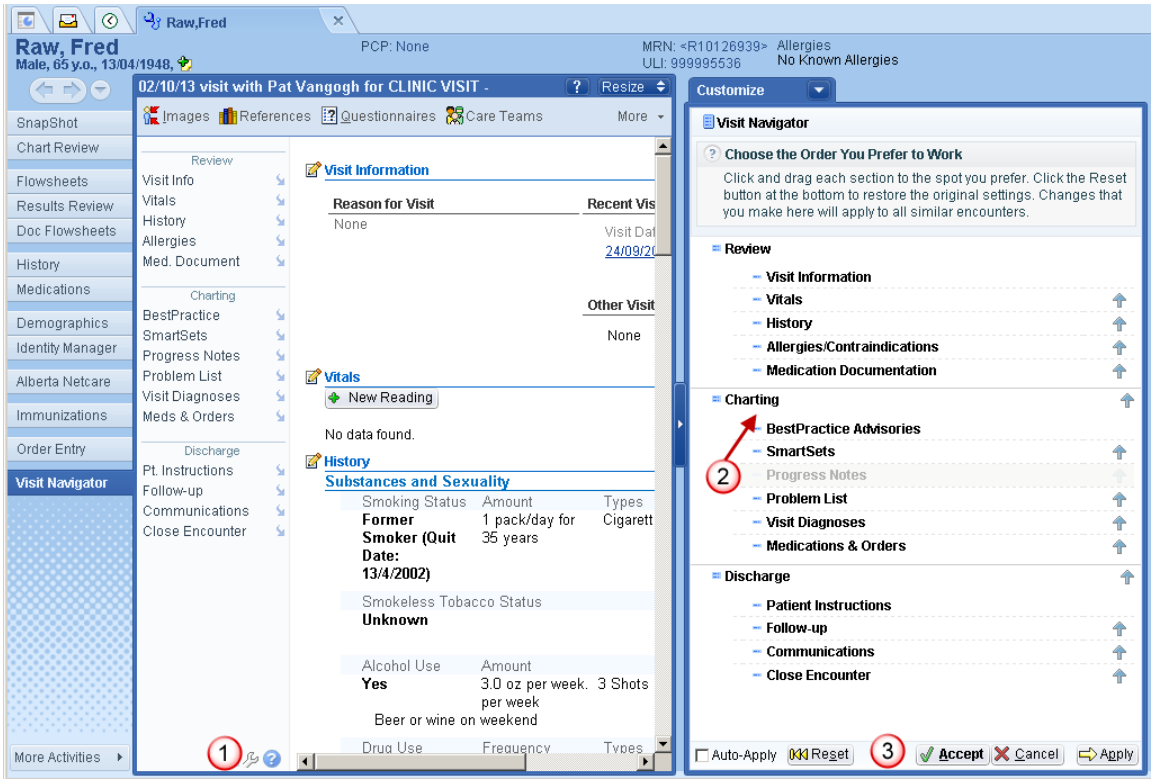
   The Personalization Activity displays with two panes: Personalize This Workspace and Personalize This Toolbar.

3. From the Personalize This Workspace pane, in the My Activities section, select an activity.
4. Drag your selection to the desired position in the list.
5. Click **Accept** to save your changes.

Arrange Topics and Sections in Navigators

To assist in making your workflows more efficient, you can now arrange a navigator's table of contents in the order you prefer. You can re-arrange both topics and sections. For example, you could move the ***Charting*** topic to the top of the table of contents and the ***Progress Notes*** section to the top of the Charting topic.

1. From the bottom of the navigator table of contents, click the wrench. The Customize window displays.
2. Select your topic or sections and click and drag your selection to the desired position. Alternately, you can also use the blue arrows.
3. When you are finished, click **Accept**.



CHANGE THE APPEARANCE OF THE PROBLEM LIST

You have the ability to control the way that information displays when you are viewing the Problem List activity. You can set the display so that the information that is the most important to you is saved as your default preference.

1. Access the patient's workspace.
2. Depending on the chart mode you are using, select either the Problem List activity or the Problem List navigator section.
3. To sort the Problem List section by view, click **Options**. A List View area displays with radio buttons (blank circles).
4. Select the appropriate option.

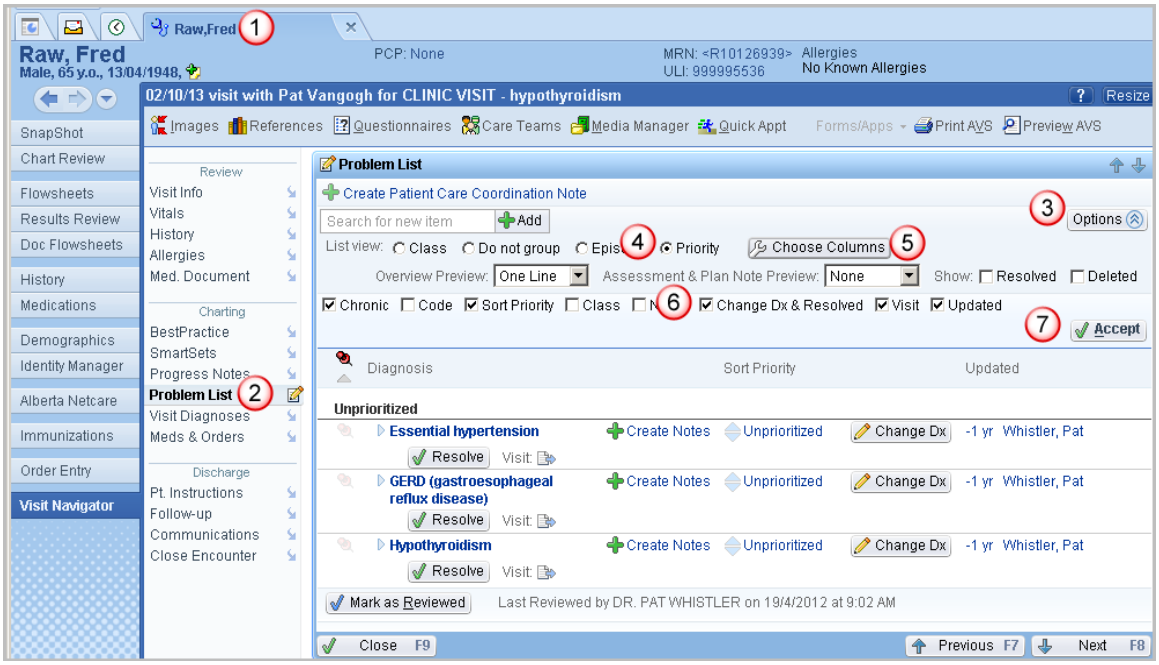
   TIP 1: The Class List view option is not currently being used.

5. To add or remove data items available for display, click **Choose Columns**. Beneath the List View area, a series of checkboxes display.
6. Select or deselect the appropriate data items.

View Changed and Resolved Problems

We strongly recommend that your Problem List display include Change Dx & Resolved data item. The display of resolved problems is shown in the next section.

7. After you have finished customizing the display, click **Accept**. The data items that now display by default match your selections.



Sorting by Priority

- Click the up and down arrow buttons under the Sort Priority column, to assign priorities of High, Medium or Low.
- As you assign priority and move away from the arrows, the problems list re-sorts.
- Hover your mouse over the arrow buttons. A ToolTip displays the priority that is assigned if you click the button.
- Once you move the cursor, the problem is momentarily highlighted in green and is re-sorted.

CHANGE THE APPEARANCE OF THE MEDICATIONS & ORDERS SECTION

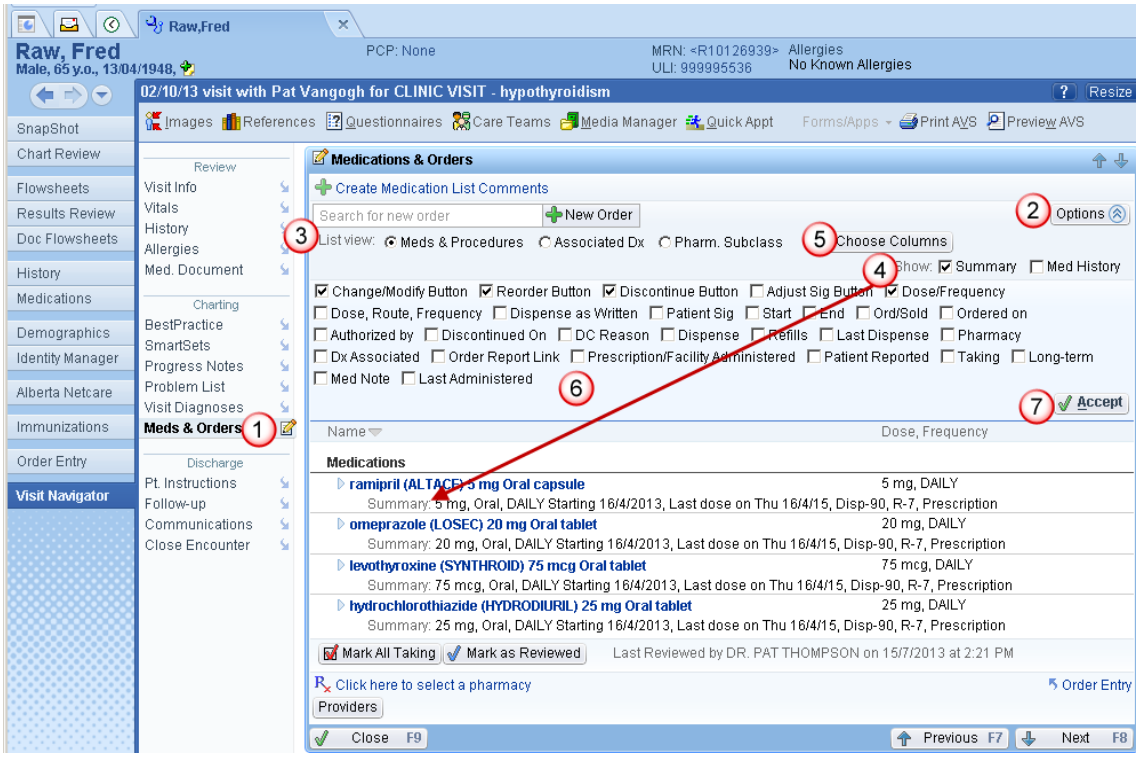
You can control the way that information displays when you are viewing the Medications and Orders Visit Navigator section.

1. From the Visit Navigator table of contents, access the Meds & Orders section.
2. To organize your orders into different groups, click **Options**. A List View area displays with radio buttons.
3. From the List view area, select the appropriate display option. In this example, medications and procedure orders are grouped separately.

Pharm. Subclass Option

The Pharm. Subclass option cannot be used as the source for medications in ***e*CLINICIAN**, First Databank (FDB) Canada, does not provide this information.

4. To reveal additional details about the items that have been ordered, select the Show: Summary checkbox. In this example, the Show: Summary option displays a one line summary of each order.
5. To choose the information to display beside each medication, click **Choose Columns**. A list of options display with checkboxes.
6. Select or deselect the appropriate options.
7. To save the options you selected, click **Accept**. The data items you selected display beside each medication as columns or buttons in your default display.


Raw,Fred
Raw, Fred
Male, 65 y.o., 13/04/1948,
PCP: None
MRN: <R10126939>
ULI: 999995536
Allergies
No Known Allergies
02/10/13 visit with Pat Vangogh for CLINIC VISIT - hypothyroidism
Resize
Images
References
Questionnaires
Care Teams
Media Manager
Quick Appt
Forms/Apps
Print AVS
Preview AVS
SnapShot
Chart Review
Flowsheets
Results Review
Doc Flowsheets
History
Medications
Demographics
Identity Manager
Alberta Netcare
Immunizations
Order Entry
Visit Navigator
Review
Visit Info
Vitals
History
Allergies
Med. Document
Charting
BestPractice
SmartSets
Progress Notes
Problem List
Visit Diagnoses
Meds & Orders
Discharge
Pt. Instructions
Follow-up
Communications
Close Encounter
Medications & Orders
Create Medication List Comments
Search for new order
New Order
Options
List view:
Meds & Procedures
Associated Dx
Pharm. Subclass
Choose Columns
Show:
Summary
Med History
Change/Modify Button
Reorder Button
Discontinue Button
Adjust Sig Button
Dose/Frequency
Dose, Route, Frequency
Dispense as Written
Patient Sig
Start
End
Ord/Sold
Ordered on
Authorized by
Discontinued On
DC Reason
Dispense
Refills
Last Dispense
Pharmacy
Dx Associated
Order Report Link
Prescription/Facility Administered
Patient Reported
Taking
Long-term
Med Note
Last Administered
Accept
Name
Dose, Frequency
Medications
ramipril (ALTACE) 5 mg Oral capsule
5 mg, DAILY
Summary: 5 mg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription
omeprazole (LOSEC) 20 mg Oral tablet
20 mg, DAILY
Summary: 20 mg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription
levothyroxine (SYNTHROID) 75 mcg Oral tablet
75 mcg, DAILY
Summary: 75 mcg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription
hydrochlorothiazide (HYDRODIURIL) 25 mg Oral tablet
25 mg, DAILY
Summary: 25 mg, Oral, DAILY Starting 16/4/2013, Last dose on Thu 16/4/15, Disp-90, R-7, Prescription
Mark All Taking
Mark as Reviewed
Last Reviewed by DR. PAT THOMPSON on 15/7/2013 at 2:21 PM
Click here to select a pharmacy
Order Entry
Providers
Close F9
Previous F7
Next F8
1
2
3
4
5
6
7

BUILD PATIENT LISTS

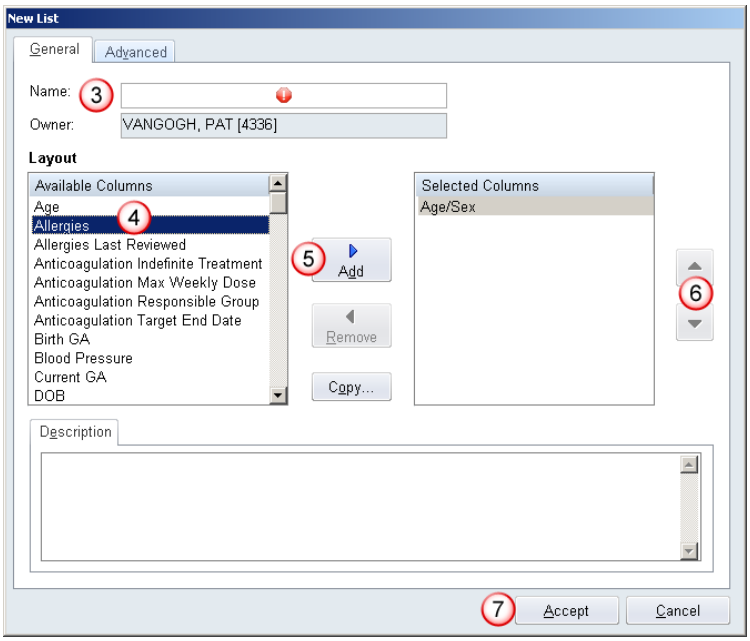
You can use the Patient Lists activity to create and maintain lists of patients. These lists provide you with easy access to patients that you are monitoring.

CREATE A PATIENT LIST

1. From the **Epic** button, select **Patient Care > Patient Lists**. The Patient Lists activity displays in a new workspace.
2. To create a new list, on the activity toolbar, click **Edit List** > **Create My List**. The New List window displays with a General tab and an Advanced Tab.
3. From the General tab, in the **Name** field, type a name for the list.
4. From the Layout section, select a column of information to display in your report. For some columns, a brief description of information that will appear in the report displays.
5. Click **Add**. Your selections display in the Selected Columns section.
6. If required, use the Up and Down arrows to reorder the columns.

   TIP: Use the **Advance tab** to share your list with other providers. To indicate what the provider can do with the list, specify an **Access Level**, such as Modify Properties, Add/Remove Patients, or View Only.

7. When you are done, click **Accept**.



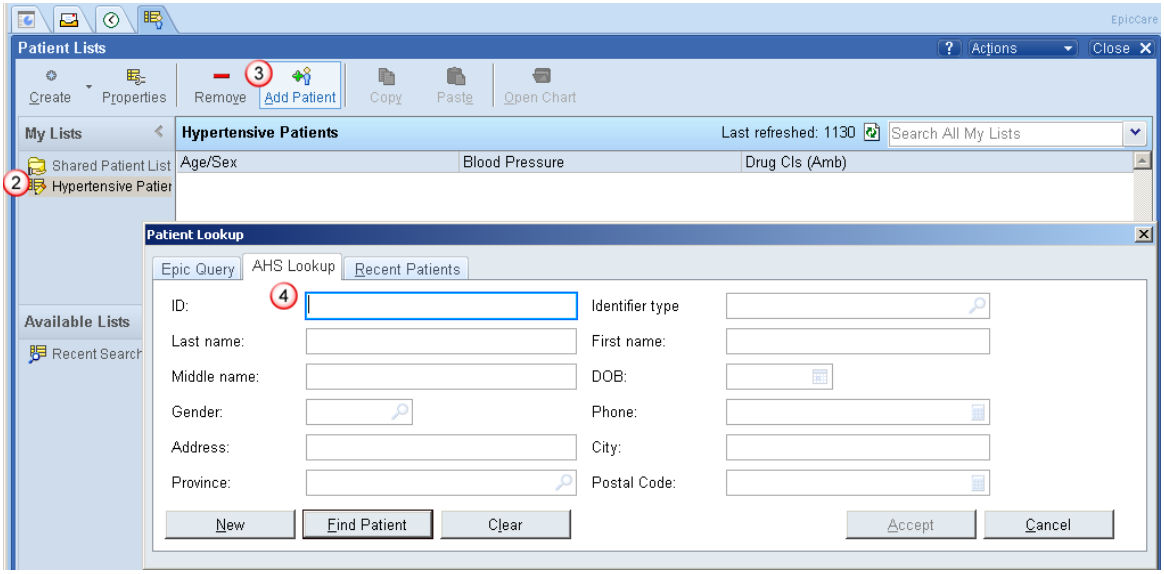
Patient List Access

There are various levels of access:

- View Only: The user can open the list but cannot modify it in any way.
- Add/Remove Patients: The user can add or remove patients to the list.
- Modify Properties: The user can modify the list, in addition to the previously mentioned abilities.
- Change Accessibility: The user can change the accessibility of him/herself or other users, in addition to the previously mentioned abilities.
- Delete Patient List: The user can delete the list, in addition to the previously mentioned abilities.

ADD PATIENTS TO A PATIENT LIST FROM THE PATIENT LIST ACTIVITY

1. From the **Epic** button, select **Patient Care > Patient Lists**. The Patient Lists activity displays in a new workspace.
2. In the left pane, under My Lists, select the appropriate List. The name of the list displays in the upper right-hand pane.
3. On the activity toolbar, click **Add Patient**. The Patient Lookup window displays.
4. Search for and select the appropriate patient record. The information for that patient displays below the list name in the upper right-hand pane.

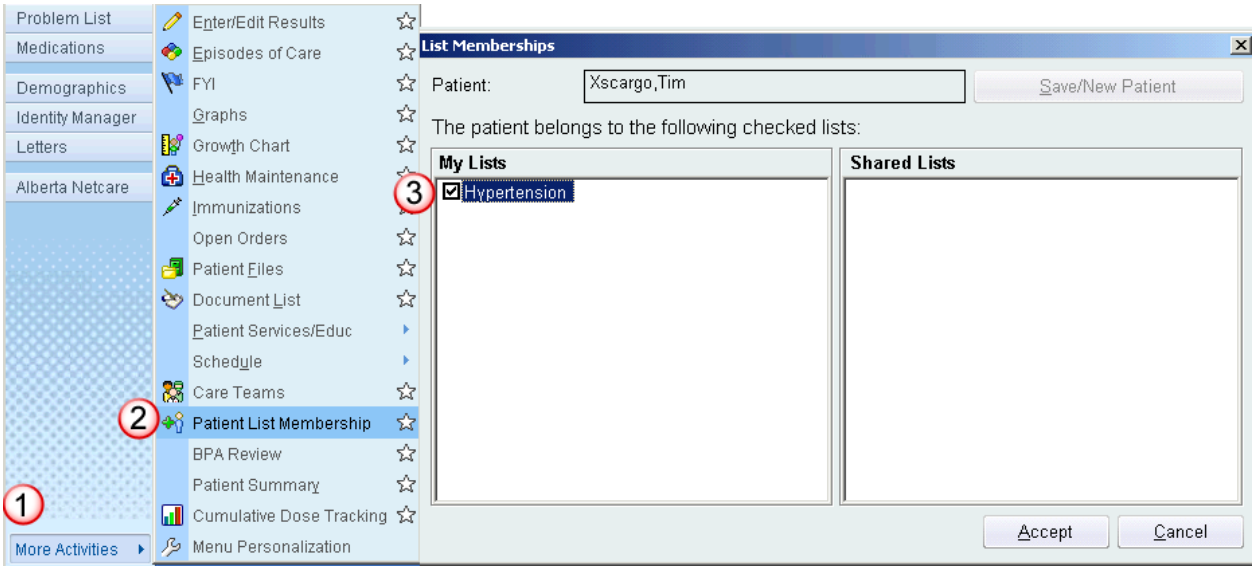


Additional Patient List features

- Edit your list by selecting it under My Lists and clicking **Properties** on the activity toolbar.
- Open a patient's chart from your list by double-clicking the patient's name.
- In the patient's chart, access the Demographics activity and go to the **Clinical Information** to view all of **your** patient lists that this patient belongs to.

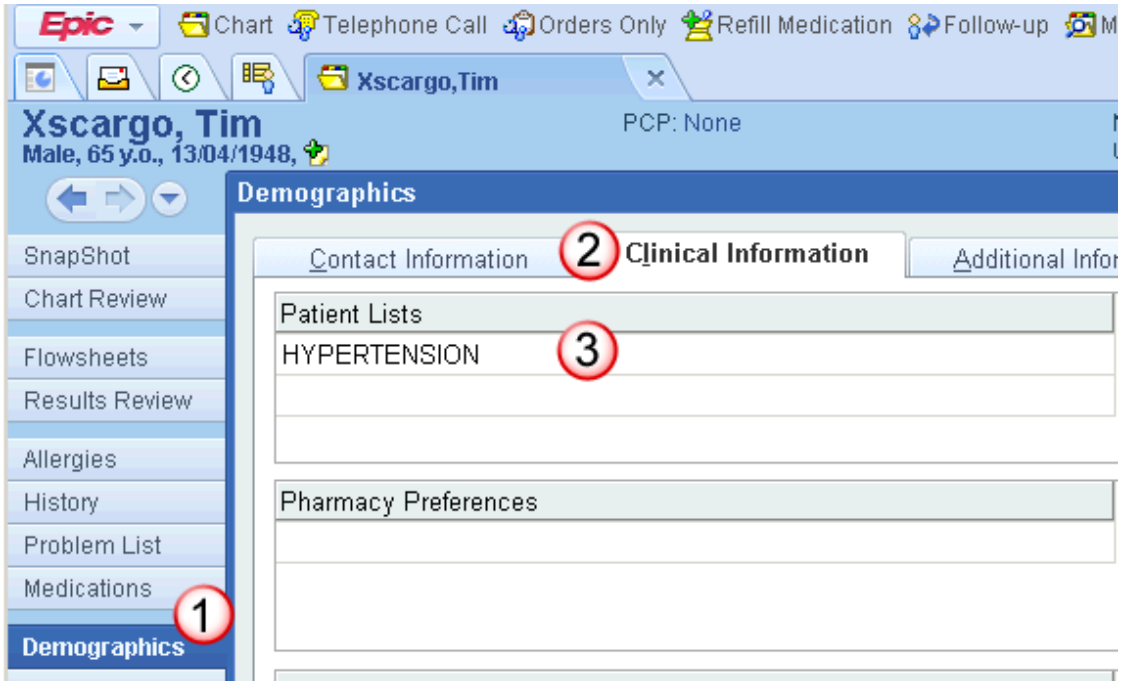
ADD A PATIENT TO A PATIENT LIST FROM THE PATIENT'S CHART

1. From the patient's chart in review or documentation mode, click **More Activities**.
2. Select Patient List Membership.
3. Select the appropriate list from the My Lists or Shared Lists columns and click **Accept**.



REVIEW WHICH PATIENT LISTS THE PATIENT IS ON

1. From the patient's chart in review or documentation mode, access the Demographics activity.
2. Select the Clinical Information tab.
3. Any lists to which the patient belongs are listed in the Patient Lists section.



CREATE A CUSTOM DICTIONARY

You can create your own unique custom dictionary in ***e*CLINICIAN - EMR**. Your custom dictionary can be used wherever there is spell check functionality. Not all names and terms are available in the default dictionary (i.e. personal names and acronyms), therefore adding them to your custom dictionary will ensure that they are correctly spelled at all times and won't continue to be flagged by Spell Checker.

Note that your dictionary does not impact the current default American English Medical (AEM) dictionary.

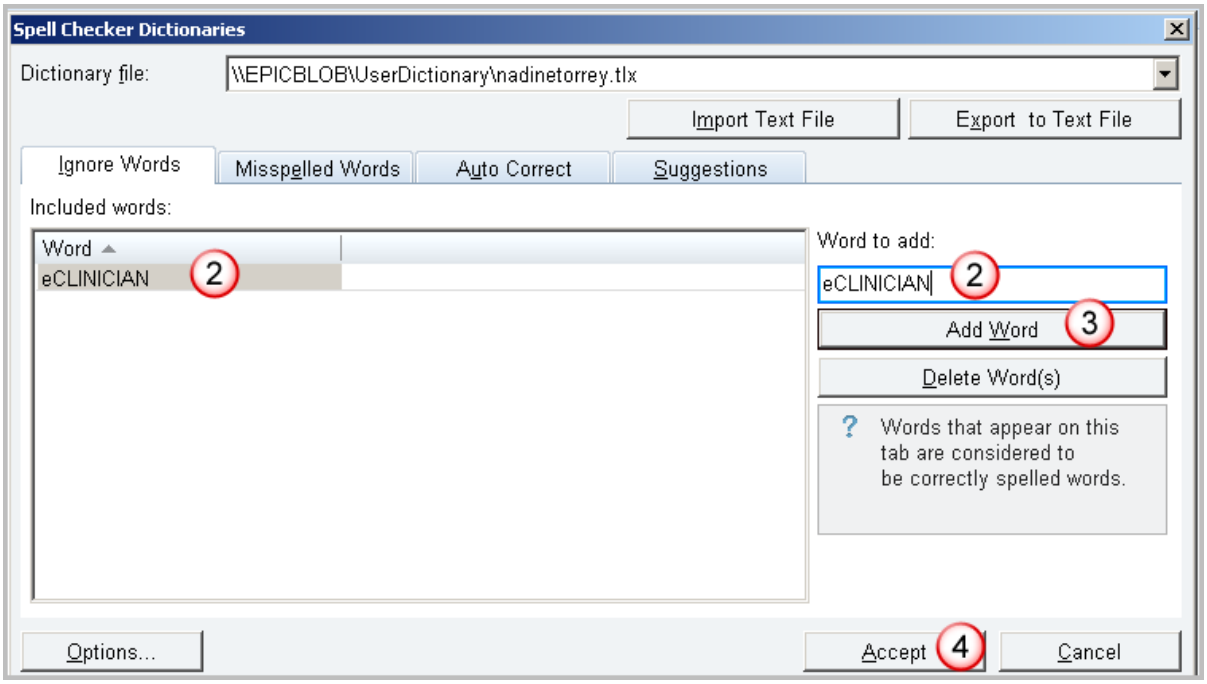
There are two ways you create your custom dictionary:

FROM THE EPIC MENU

1. From the **Epic** button, select **Tools > Spell Checker > User Dictionaries**. The Spell Checker Dictionaries window displays.

   The name of the Dictionary file is automatically created using your name. Neither the file name nor the location can be changed.

2. In the Word to add field, type the new word.
3. Click **Add Word**.The word is saved in your custom dictionary.



4. To save your changes and close the dictionary, click **Accept**.

Additional Information

The **Import Text File** and **Export to Text File** buttons are not supported functions.

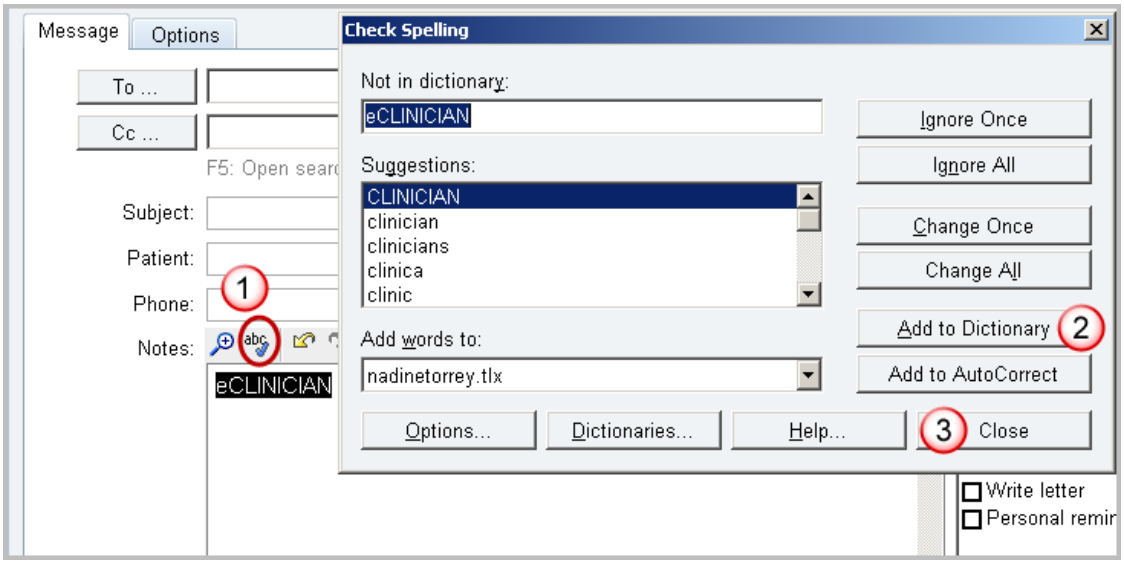
The remaining tabs and buttons are similar to the dictionary functionality in Microsoft Word®.

FROM A SMARTTOOL-ENABLED TOOLBAR

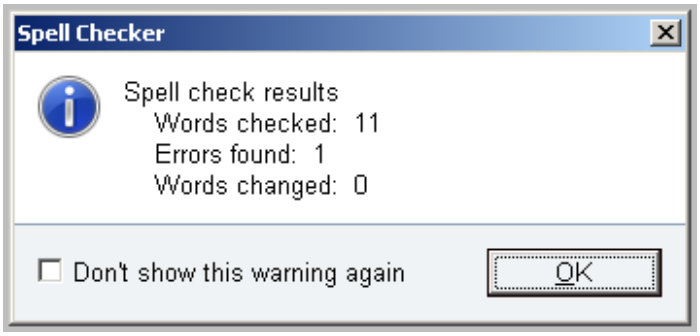
1. From a SmartTool-enabled toolbar, click the **Spell Check** button or press **F7**.

   If the Spell Checker encounters a word that is not found in the default dictionary or in your custom dictionary, the Check Spelling window displays.

2. To add the new word, in the Check Spelling window, click **Add to Dictionary**.
3. Either finish cycling through the rest of the document using the Spell Checker, or click **Close**.



A Spell Checker box displays the spell check results.



4. To return to your documentation, click **OK**.

PERSONALIZE FEATURES OF THE VISIT NAVIGATOR

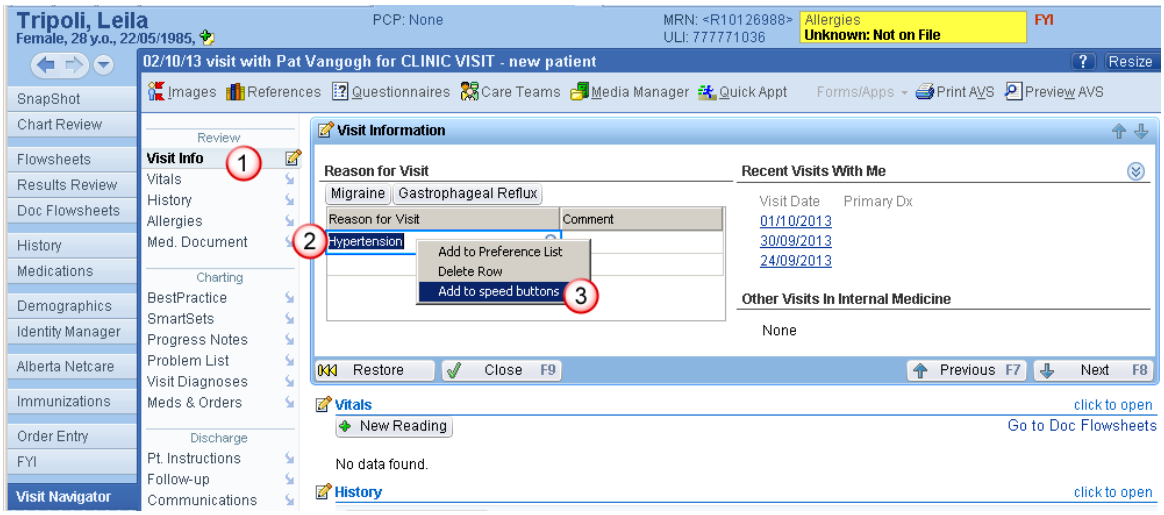
CREATE REASON FOR VISIT SPEED BUTTONS

You can create speed buttons for common reasons for visit, such as Migraine and Gastrophageal Reflux, as shown in the example below. Speed Buttons allow you to select common reasons for visits with a single click.

To create speed buttons:

1. From the Visit Navigator table of contents, access the Visit Info section.
2. In the **Reason for Visit** field, completion match on a reason for visit.
3. In that same field**, right-click** and select Add to speed buttons. The speed button appears immediately under the Reason for Visit column title.

Speed buttons are accessible from any patient's workspace.

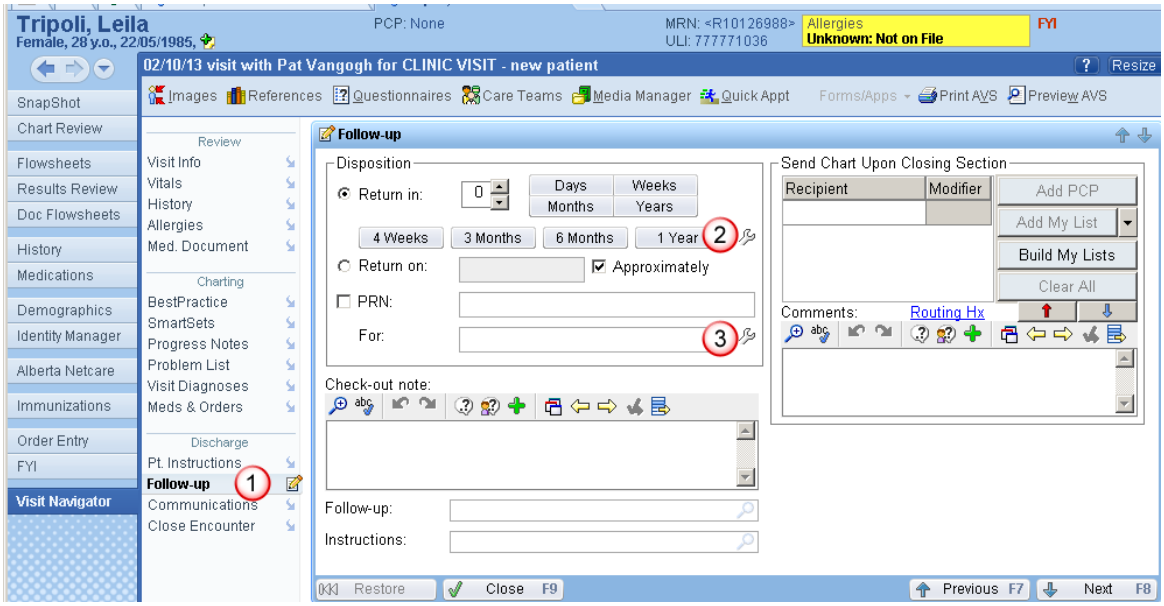


4. To remove speed buttons, **right-click** on the existing reason for visit (with a corresponding speed button) and select Remove from speed buttons.

CREATE FOLLOW-UP SPEED BUTTONS

To increase efficiency in your workflow, speed buttons are now available in the Follow-up section. You have the ability to edit the default buttons and create new ones.

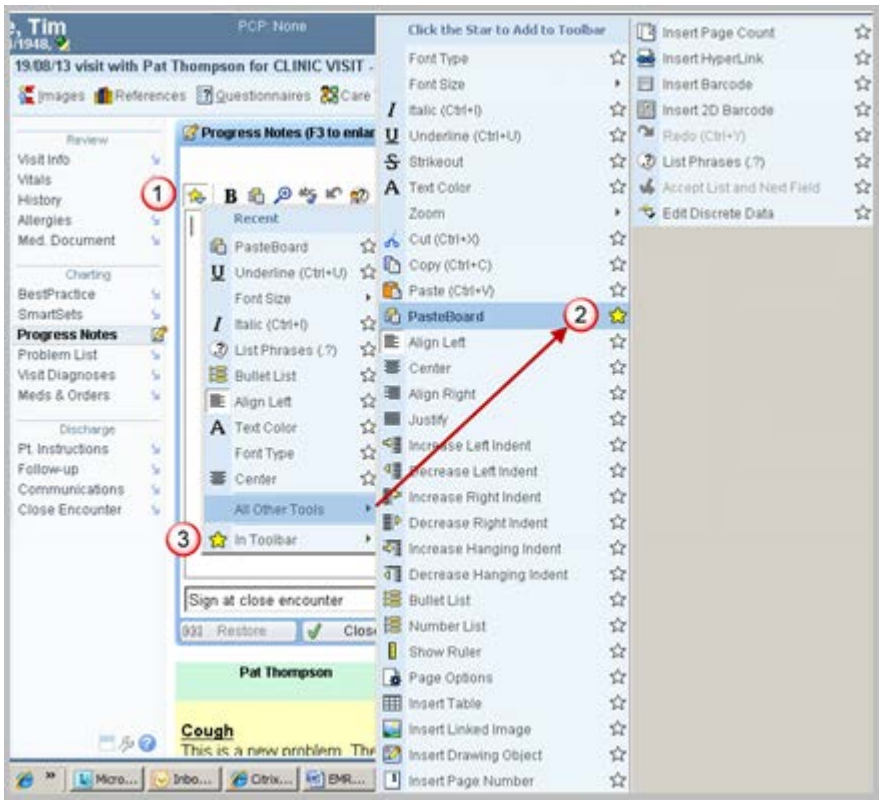
1. From the Visit Navigator table of contents, access the Follow-up section.
2. To edit or add a new **Return in** speed button, in the Disposition area, click the wrench.
3. To add a **Reason for Return** speed button, click the corresponding wrench.



CUSTOMIZE THE APPEARANCE OF THE SMARTTOOLS TOOLBAR

The SmartTools toolbar is available in several activities. You can customize the SmartTools toolbar and add the buttons you use most often.

1. From most SmartTool enabled text boxes, such as the Progress Notes or Pt. Instruction sections, on the far left of the toolbar, click the yellow star. A menu displays.
2. To expand the menu, click All Other Tools. Locate the button you want to add and to the right of it, and click the white star. The star turns yellow.
3. The new item displays on your toolbar.

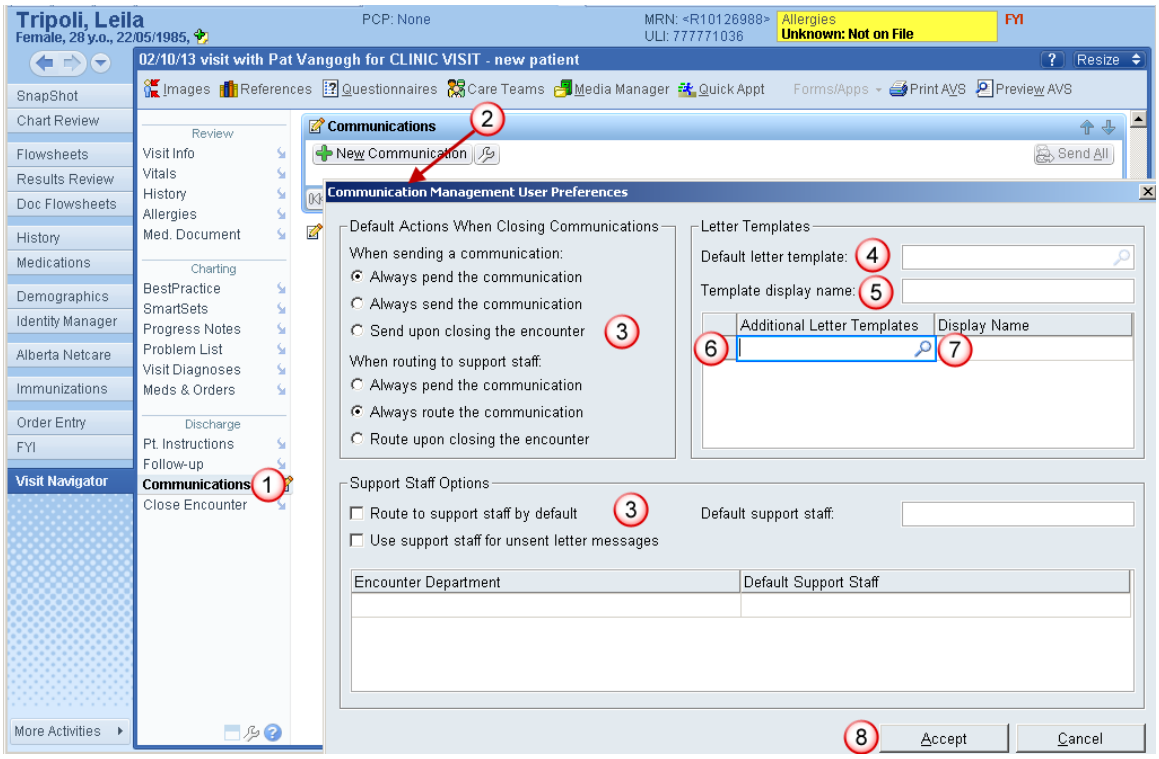


4. To remove a button from the toolbar, click the yellow star.

SETTING COMMUNICATIONS PREFERENCES

The Communications navigator section improves your efficiency by allowing you to personalize several features.

1. From the Visit Navigator table of contents, access the Communications section.
2. To begin personalizing this section, next to New Communication, click the wrench. The Communication Management User Preferences window displays.
3. From here you can set defaults for sending communications and routing to support staff or to the letter's author.
4. To customize the display name for letter templates, In the Letter Templates area, in the **Default letter template** field, click the **Selection** tool (magnifying glass) and select a letter template.
5. In the **Template display name** field, enter the name you want to display on the button.
6. To add more letter templates, in a blank field under Additional Letter Templates, click the **Selection** tool to locate the letter template.
7. Enter a **Display Name**.
8. When you are finished customizing, click **Accept**.



PERSONALIZE FEATURES OF THE CHART REVIEW ACTIVITY

The filter functionality in the Chart Review activity allows you to search patient data using predetermined criteria. For example, you can create a filter that shows only visits for which you were the physician. You can also filter on specific medications, orders, chief complaint, and more.

Quick Filters take the functionality one step further by allowing you to save your most frequently used filters. By saving your personal (Quick) filter you can quickly sort data in the future.

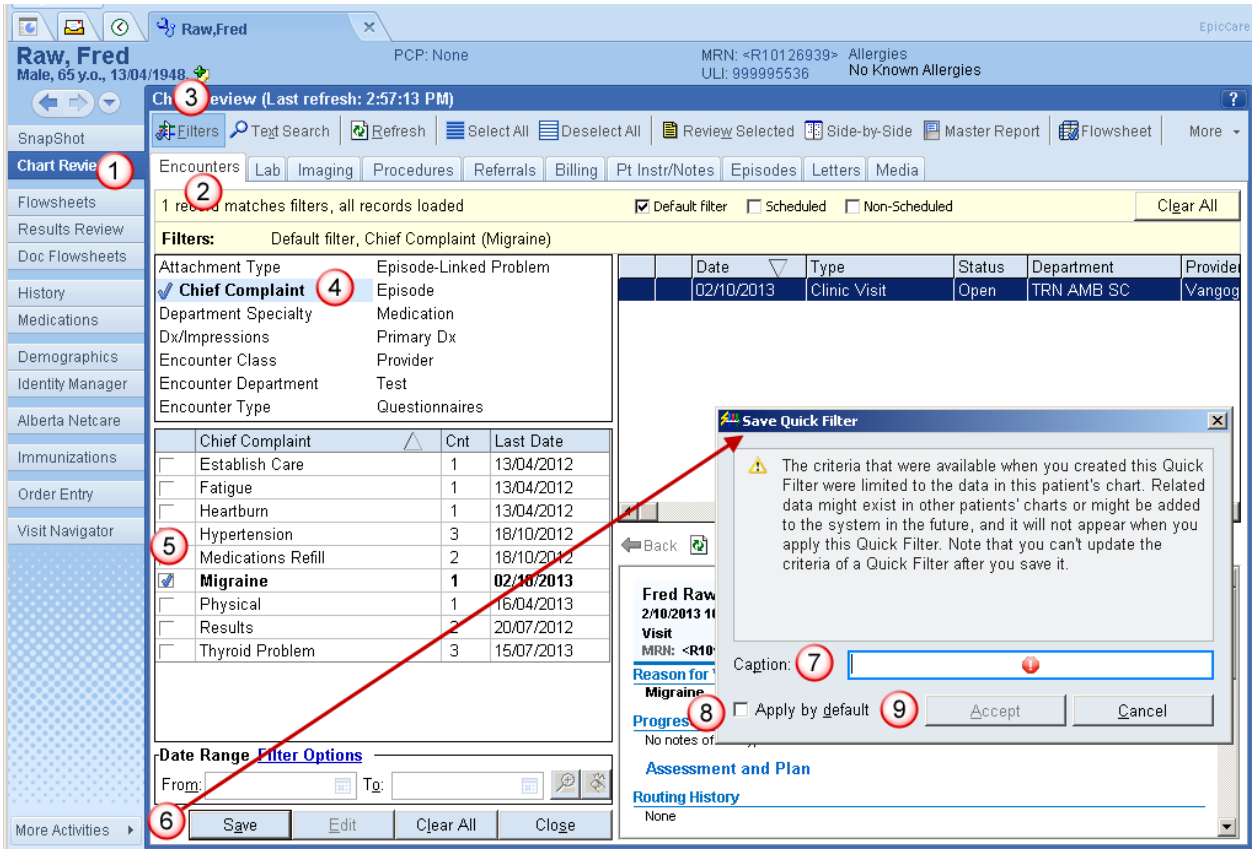
CREATE A PERSONAL CHART REVIEW FILTER

1. From the left-hand side of the patient's workspace, select the Chart Review activity.
2. Access the appropriate tab on the Chart Review activity.
3. From the toolbar, click **Filters**. In the upper left-hand pane, a list of filter categories displays. In the right-hand pane, the report entries for the patient displays.
4. Select one of these categories. In the lower left pane, a list of patient-specific entries belonging to that category display with checkboxes.
5. Select as many checkboxes as you need to refine your filter. As you make your selections, the list in the right-hand pane gets smaller, displaying only those entries matching your filter criteria.

   TIP: You can create complex filters by selecting more than one category. For example, you can filter once on all of the tests for a particular provider and then filter again on all of their encounters where there was a particular diagnosis. Simply repeat **steps 4 and 5** for each category you want to add to your filter.

6. To save the personal data filter, click **Save**. The Save Quick Filter window displays.
7. In the **Caption** field, type a name for the personal data filter.
8. To have the personal data filter automatically display each time you access the appropriate tab for any patient, select the Apply by Default checkbox.
9. Click **Accept**. The personal data filter displays on the Filter title bar.

   The personal filter is saved to your user settings. Regardless of the patient you select, the personal filter is available for your use each time you open the corresponding Chart Review tab.



CREATE A PERSONAL LAB FLOWSHEET

On the Lab tab, the Quick Filter functionality can be combined with the Lab Flowsheet display to create personal lab flowsheets. For example, you can create a personal lab flowsheet that quickly shows you the screening tests that are most meaningful for your specialty.

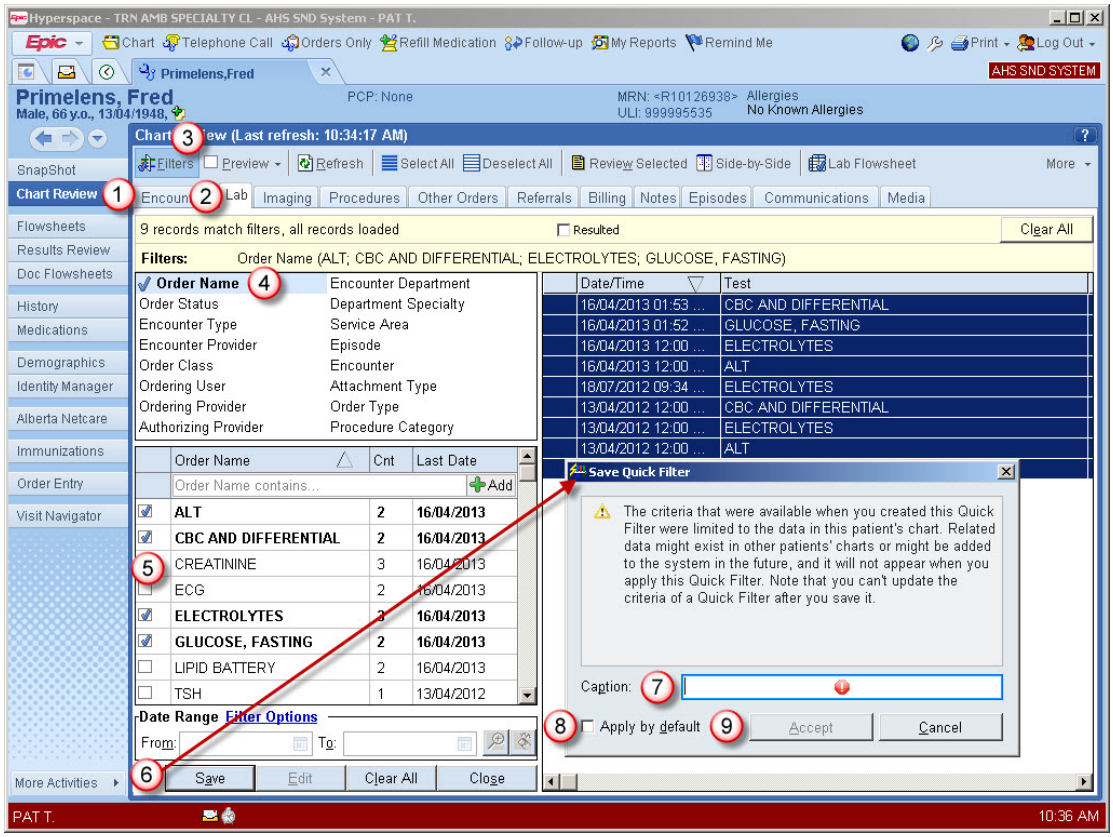
1. From the left-hand side of the patient's workspace, select the Chart Review activity.
2. Access the Lab tab on the Chart Review activity.
3. From the toolbar, click **Filters**. In the upper left-hand pane, a list of filter categories displays. In the right-hand pane, the results available for the patient display.
4. Select one of these categories (e.g. ***Order Name***). In the lower left pane, a list of patient-specific results belonging to that category display with checkboxes.

   TIP 1: If the patient whose chart you are using to build the personal flowsheet has not had a particular test ordered, you are not able to add that test to the flowsheet.

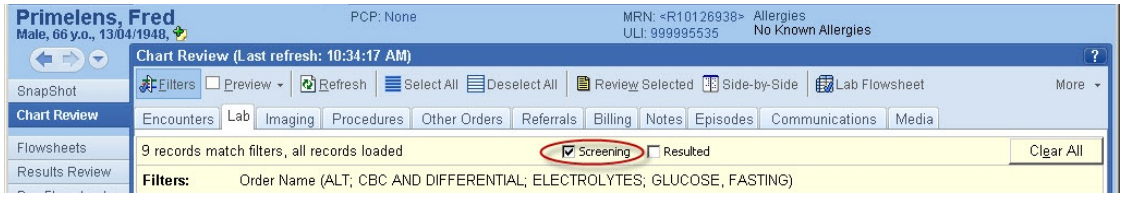
5. Select as many checkboxes as you need to refine your filter. As you make your selections, the list in the right-hand pane gets smaller, displaying only those results matching your filter criteria.

TIP 2: You can create complex filters by selecting more than one category. For example, you can filter once on all of the tests for a particular provider and then filter again on all of their encounters where there was a particular diagnosis. Simply repeat **steps 4 and 5** for each category you want to add to your filter.

6. To save the personal data filter, click **Save**. The Save Quick Filter window displays.
7. In the **Caption** field, type a name for the personal data filter.
8. To have the personal data filter automatically display each time you access the Lab tab for any patient, select the Apply by Default checkbox.
9. Click **Accept**.



The personal data filter displays on the Filter title bar.



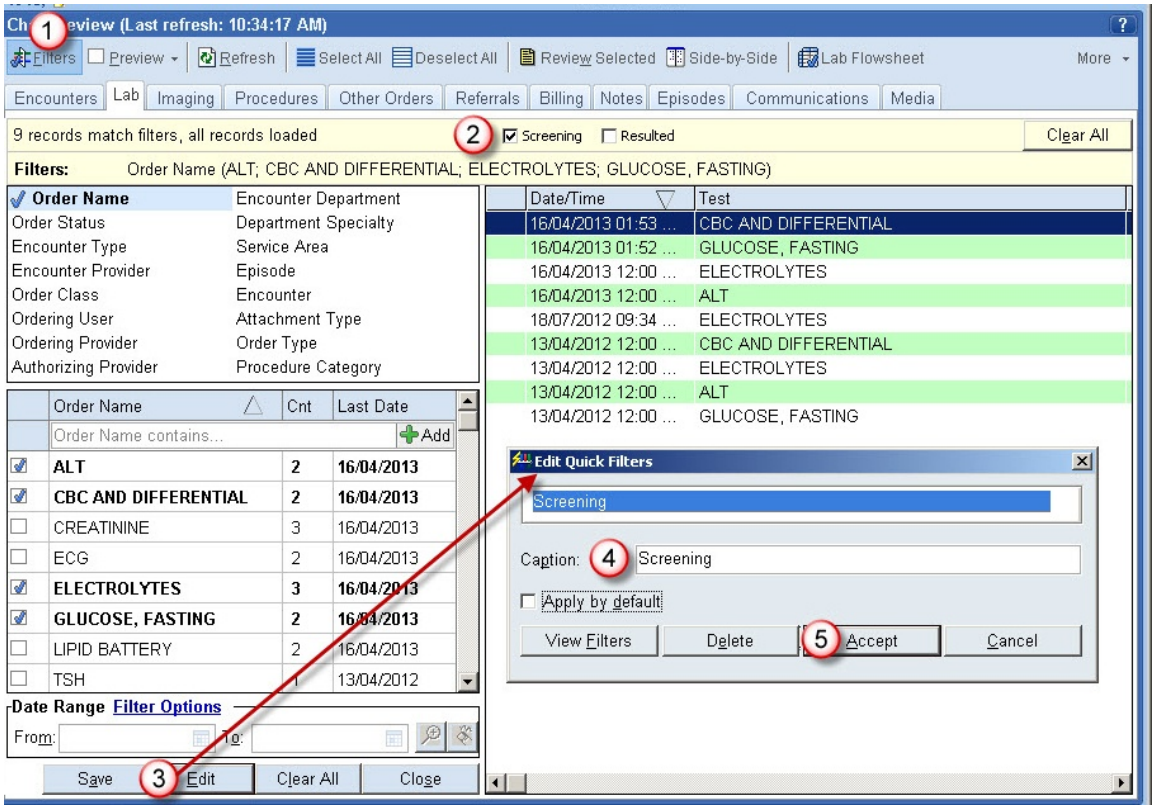
The personal filter is saved to your user settings. Regardless of the patient you select, the personal filter is available for your use each time you open the Chart Review > Lab tab.

MODIFY A PERSONAL DATA FILTER/LAB FLOWSHEET

The Quick Filter edit feature allows you to change only the name of your personal filter/flowsheet or to delete it. It does not allow you to add or remove selections from the filter/flowsheet. To add or remove selections, you must delete the filter/flowsheet and create the new version.

CHANGE THE NAME OF YOUR PERSONAL FILTER

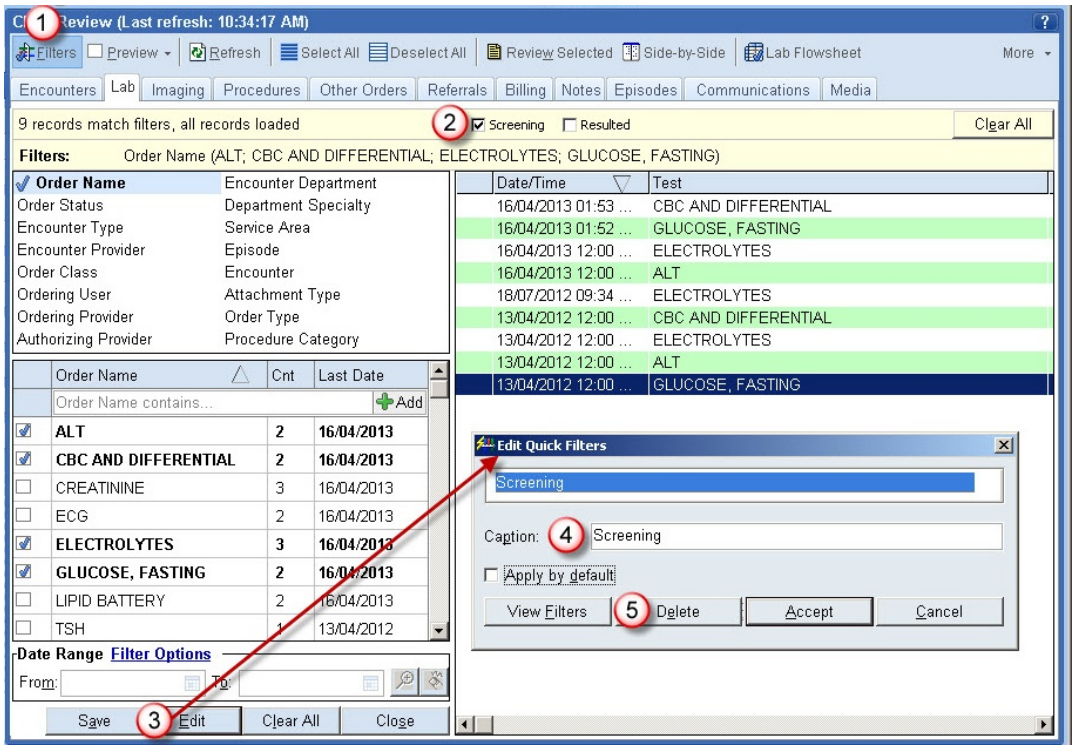
1. From the appropriate tab, click **Filters**
2. Apply the appropriate personal filter/flowsheet.
3. In the lower left-hand area, click **Edit**. The Edit Quick Filters window displays.
4. In the **Caption** field, type the new name of the filter.
5. Click **Accept**.



The new name for your personal lab flowsheet filter displays on the Filter title bar.

DELETE YOUR PERSONAL FILTER

1. From the appropriate tab, click **Filters**
2. Apply the appropriate personal filter/flowsheet.
3. In the lower left-hand area, click **Edit**. The Edit Quick Filters window displays.
4. In the **Caption** field, type the new name of the filter.
5. Click **Delete**.



6. Click **Accept**. The personal filter/flowsheet is removed from the Filter title bar.

ADD OR REMOVE SELECTIONS FROM YOUR PERSONAL FILTER

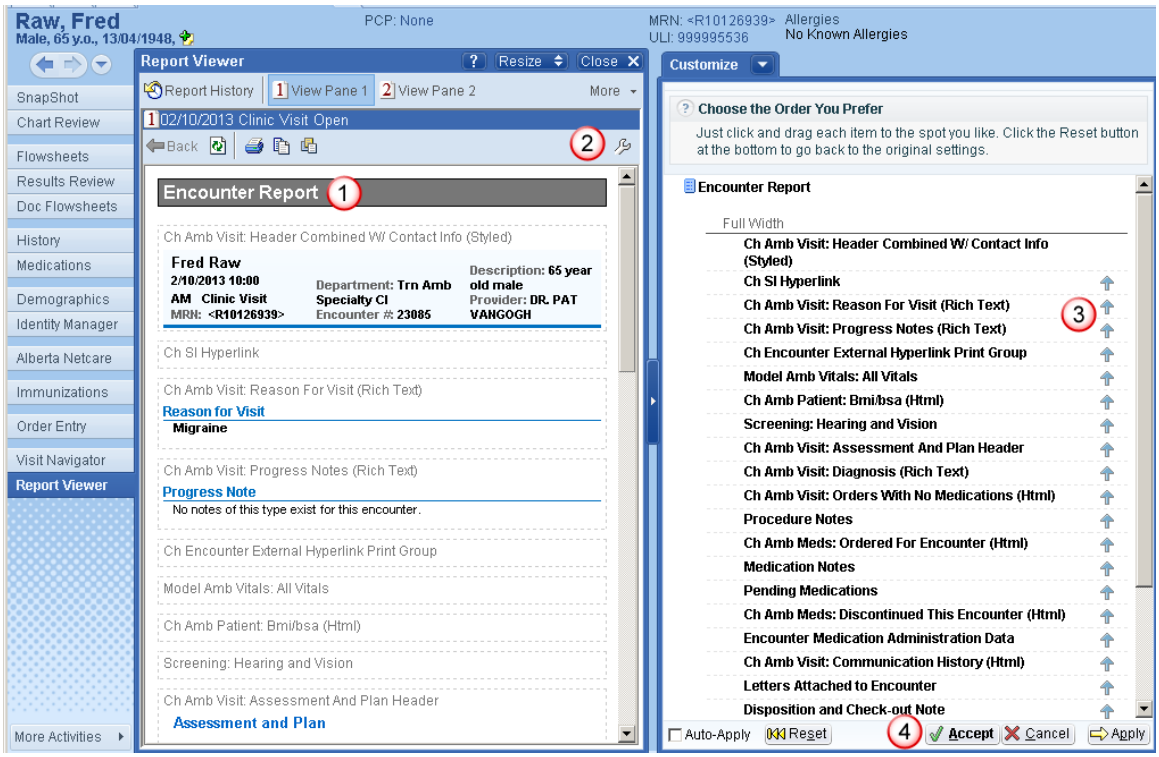
1. From the Lab tab, select the custom lab flowsheet filter.
2. Check or uncheck the appropriate filter selections.
3. Click **Save**. The Save Quick Filter window displays.
4. In the **Caption** field, enter a name for your updated filter.
5. To have the filter automatically display on the Filter title bar, select the **Apply by Default** field.
6. Click **Accept**. The newly updated filter displays on the Filter title bar each time you open the Chart Review > Lab tab.

7. If required, follow the steps in the previous topic to delete the previous version of your custom filter.

CUSTOMIZE CHART REVIEW REPORTS

To save time, you can customize the order of Chart Review reports to first display the information most important to you, and group related pieces of information together, limiting the amount of time you spend scrolling through the report.

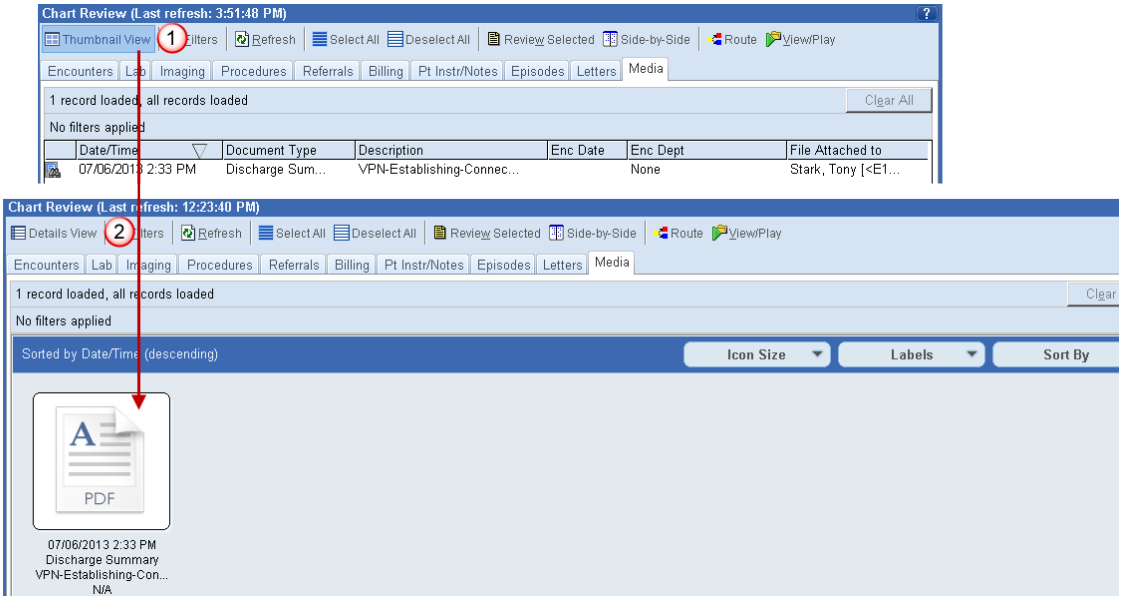
1. In Chart Review, open a report you want to customize.
2. On the right-hand side of the Report Viewer toolbar, click the wrench. On the right, a Customize window displays.
3. Click and drag each item to the order you prefer or use the blue arrow.
4. Click **Accept**.



DISPLAY MEDIA TAB THUMBNAILS

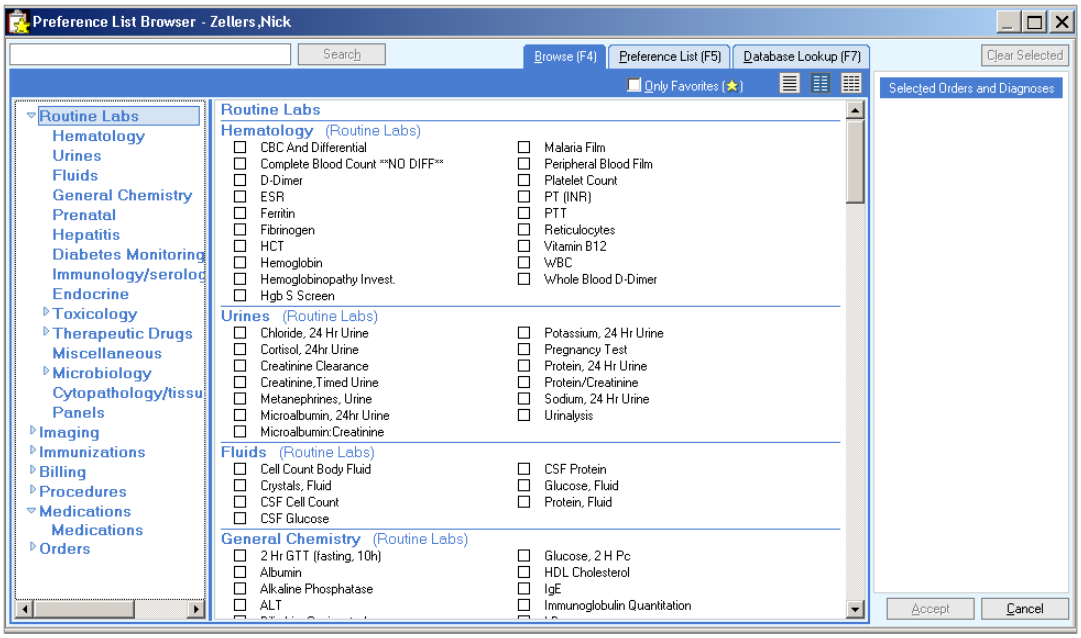
The new Thumbnail View in the Media tab of Chart Review makes it easier to see the type of file that has been scanned.

1. From the Media tab toolbar, click **Thumbnail View**. The listed reports change to thumbnails.
2. To return to the previous view, click **Details View**.



MANAGE PERSONAL PREFERENCE LISTS OUTSIDE OF ENCOUNTERS

Preference Lists are a great way to help you quickly place orders for medications and procedures that you most commonly use.



Each time you need to order one of these common medications or procedures, a simple technique can be used to place the order.

As a reminder, there are two types of preference lists:

- System preference lists are built by the ***e*CLINICIAN - EMR** project team to reflect ordering practices for a defined group of users such as your specialty.
- Personal (user) preference lists are built by users. You can add orders to your personal preference list so that they reflect common orders or your unique ordering practices.

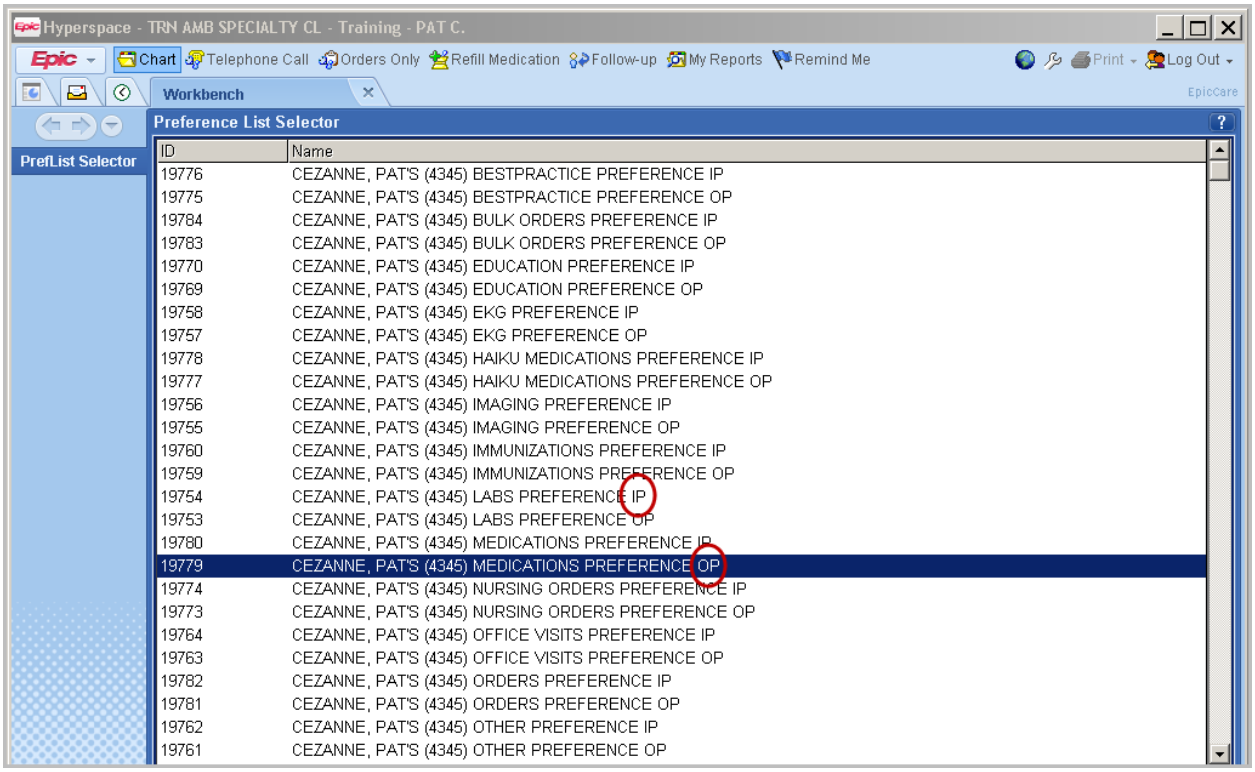
The Enter Orders chapter of this guide describes how to add an item to your personal preference list while in a patient encounter.

This section shows you how to add orders to your preference lists outside of a patient encounter as well as how to manage those orders once they are on your personal preference lists.

PLAN THE STRUCTURE OF YOUR PERSONAL PREFERENCE LISTS

Outside of a patient encounter, you can add or modify items on your personal preference lists. Prior to building out your personal preference lists, we strongly recommend that you take some time to pre-plan the structure of your preference lists.

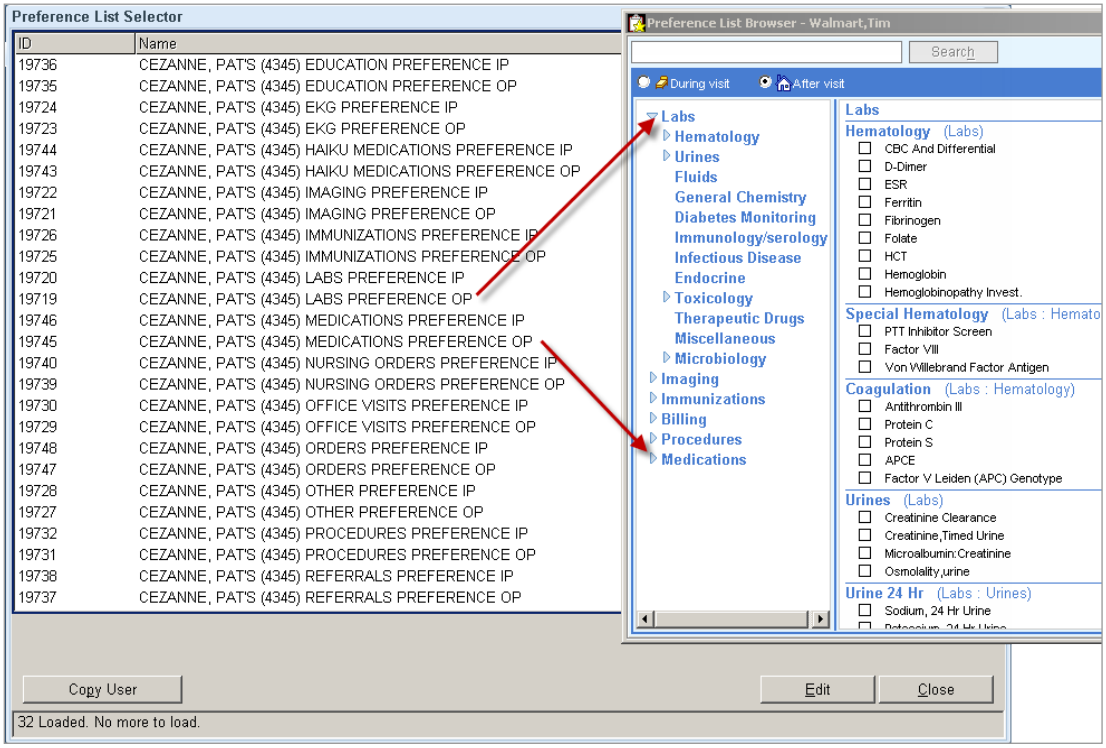
This functionality is available to from the Epic button> Tools> Preference List Composer. When you first open the Preference List Composer, the Preference List Selector activity displays.


Hyperspace - TRN AMB SPECIALTY CL - Training - PAT C.
Epic
Chart
Telephone Call
Orders Only
Refill Medication
Follow-up
My Reports
Remind Me
Print
Log Out
Workbench
EpicCare
Preference List Selector
PrefList Selector
ID
Name
19776 CEZANNE, PAT'S (4345) BESTPRACTICE PREFERENCE IP
19775 CEZANNE, PAT'S (4345) BESTPRACTICE PREFERENCE OP
19784 CEZANNE, PAT'S (4345) BULK ORDERS PREFERENCE IP
19783 CEZANNE, PAT'S (4345) BULK ORDERS PREFERENCE OP
19770 CEZANNE, PAT'S (4345) EDUCATION PREFERENCE IP
19769 CEZANNE, PAT'S (4345) EDUCATION PREFERENCE OP
19758 CEZANNE, PAT'S (4345) EKG PREFERENCE IP
19757 CEZANNE, PAT'S (4345) EKG PREFERENCE OP
19778 CEZANNE, PAT'S (4345) HAIKU MEDICATIONS PREFERENCE IP
19777 CEZANNE, PAT'S (4345) HAIKU MEDICATIONS PREFERENCE OP
19756 CEZANNE, PAT'S (4345) IMAGING PREFERENCE IP
19755 CEZANNE, PAT'S (4345) IMAGING PREFERENCE OP
19760 CEZANNE, PAT'S (4345) IMMUNIZATIONS PREFERENCE IP
19759 CEZANNE, PAT'S (4345) IMMUNIZATIONS PREFERENCE OP
19754 CEZANNE, PAT'S (4345) LABS PREFERENCE IP
19753 CEZANNE, PAT'S (4345) LABS PREFERENCE OP
19780 CEZANNE, PAT'S (4345) MEDICATIONS PREFERENCE IP
19779 CEZANNE, PAT'S (4345) MEDICATIONS PREFERENCE OP
19774 CEZANNE, PAT'S (4345) NURSING ORDERS PREFERENCE IP
19773 CEZANNE, PAT'S (4345) NURSING ORDERS PREFERENCE OP
19764 CEZANNE, PAT'S (4345) OFFICE VISITS PREFERENCE IP
19763 CEZANNE, PAT'S (4345) OFFICE VISITS PREFERENCE OP
19782 CEZANNE, PAT'S (4345) ORDERS PREFERENCE IP
19781 CEZANNE, PAT'S (4345) ORDERS PREFERENCE OP
19762 CEZANNE, PAT'S (4345) OTHER PREFERENCE IP
19761 CEZANNE, PAT'S (4345) OTHER PREFERENCE OP

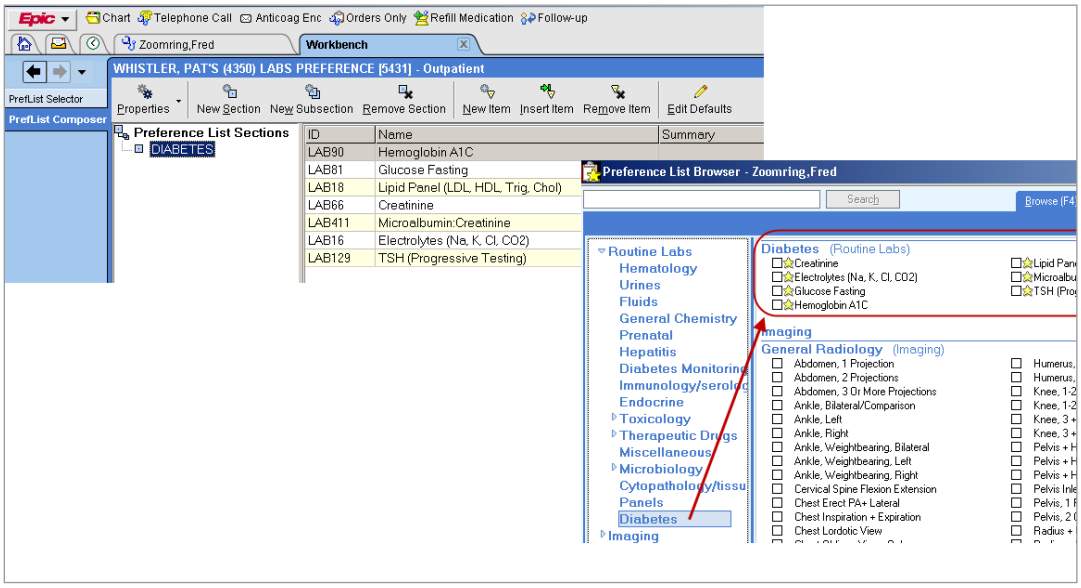
The lists that display here were automatically created when your user account was set up in ***e*CLINICIAN - EMR**. Not all of these lists are active.

When adding items to your personal preference list there is a correlation between these lists and where your personal items display on your specialty's preference list. In other words, the preference list that you see when you place an order is a combination of the system preference list that was built for your speciality and the items that you add to personalize this list. Be sure to select the list for the type of facility you work in.

Lists that end in ***IP*** are used when charting on In Patients. Lists that end in ***OP*** are used when charting on Out Patients.



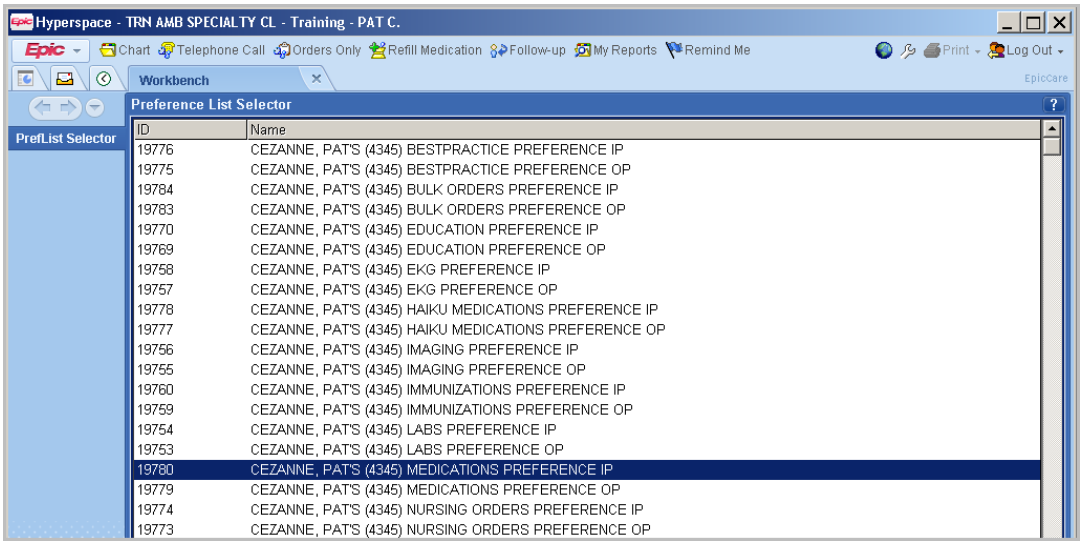
In the example below, Dr. Pat Whistler adds a new Diabetes section to her Labs Preference list using the Preference List Composer. When placing orders during an encounter, Dr. Whistler sees this section added to the Preference List Browser under Labs. A yellow star (Favorites) beside the order indicates that it is from her personal preference list.



ADD AN ORDER TO YOUR PERSONAL PREFERENCE LIST

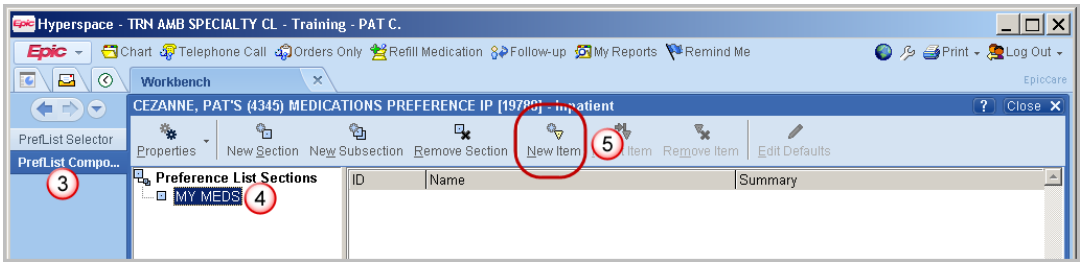
You can add an order directly to your personal preference list following the steps below.

1. Select **Epic button > Tools > Preference List Composer**. The PrefList Selector activity displays in a new workspace.
2. In the Preference List Selector activity, **double-click** the appropriate preference list.


Hyperspace - TRN AMB SPECIALTY CL - Training - PAT C.
Chart
Telephone Call
Orders Only
Refill Medication
Follow-up
My Reports
Remind Me
Print
Log Out
Workbench
Preference List Selector
PrefList Selector
ID
Name
19776 CEZANNE, PAT'S (4345) BESTPRACTICE PREFERENCE IP
19775 CEZANNE, PAT'S (4345) BESTPRACTICE PREFERENCE OP
19784 CEZANNE, PAT'S (4345) BULK ORDERS PREFERENCE IP
19783 CEZANNE, PAT'S (4345) BULK ORDERS PREFERENCE OP
19770 CEZANNE, PAT'S (4345) EDUCATION PREFERENCE IP
19769 CEZANNE, PAT'S (4345) EDUCATION PREFERENCE OP
19758 CEZANNE, PAT'S (4345) EKG PREFERENCE IP
19757 CEZANNE, PAT'S (4345) EKG PREFERENCE OP
19778 CEZANNE, PAT'S (4345) HAIKU MEDICATIONS PREFERENCE IP
19777 CEZANNE, PAT'S (4345) HAIKU MEDICATIONS PREFERENCE OP
19756 CEZANNE, PAT'S (4345) IMAGING PREFERENCE IP
19755 CEZANNE, PAT'S (4345) IMAGING PREFERENCE OP
19760 CEZANNE, PAT'S (4345) IMMUNIZATIONS PREFERENCE IP
19759 CEZANNE, PAT'S (4345) IMMUNIZATIONS PREFERENCE OP
19754 CEZANNE, PAT'S (4345) LABS PREFERENCE IP
19753 CEZANNE, PAT'S (4345) LABS PREFERENCE OP
19780 CEZANNE, PAT'S (4345) MEDICATIONS PREFERENCE IP
19779 CEZANNE, PAT'S (4345) MEDICATIONS PREFERENCE OP
19774 CEZANNE, PAT'S (4345) NURSING ORDERS PREFERENCE IP
19773 CEZANNE, PAT'S (4345) NURSING ORDERS PREFERENCE OP

The Choose Contact window displays.

3. Select the most recent record and click **Accept**. The PrefList Composer activity displays.
4. From the Preference List Sections area, select the appropriate section (or click **New Section** to create a new section).
5. From the activity toolbar, click **New Item**. The Preference List Composer window displays.



6. In the **Orderable** field, use completion matching to search for the item (order) to add.
7. In the **Display name** field, type the name to give the order.
8. Complete the remaining fields as required.

Procedure Orders - Fields to Leave Blank

Notice that none of the default values display when you add orders to your personal preference list using this method. It is important to leave certain fields blank as the appropriate field automatically populates when you place your order if a default for that field was pre-built in the order record.

- The **Status** field should be left blank unless you are setting up a Standing order or ordering an In Clinic procedure (Status = Normal).
- The **Expires** field should be left blank for all orders.

Personalizing Standing Orders

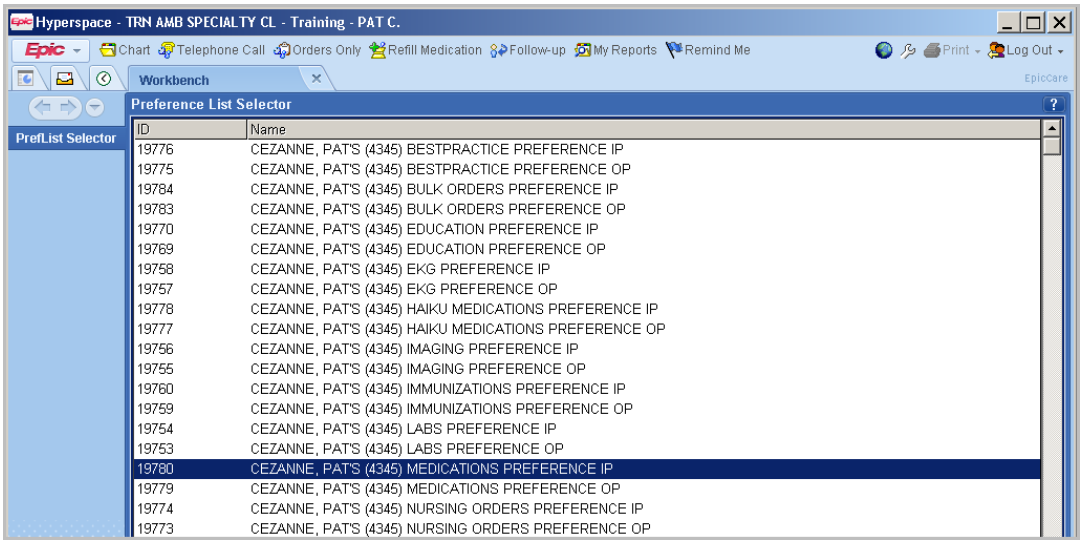
For Standing orders, the **Release** field must be set to **Manual** in order to allow you to populate the **Interval** field.

9. Click **Accept**. The new order is added to your personal preference list.

TIP: To change the order of items within a section, use the **Move Items** buttons in the lower portion of the activity. If you mistakenly add an item to the wrong section, simply drag and drop it to the correct section.

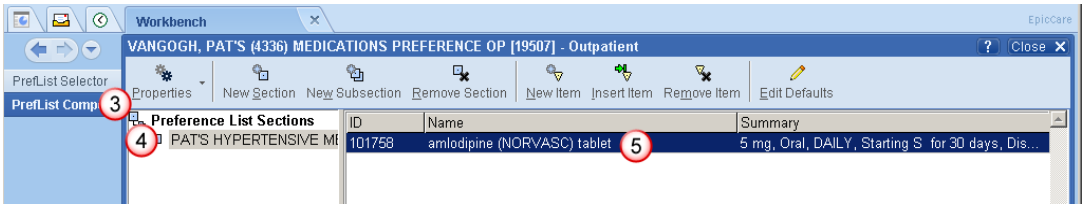
EDIT AN ITEM IN YOUR PERSONAL PREFERENCE LIST

1. Select **Epic button > Tools > Preference List Composer**. The PrefList Selector activity displays in a new workspace.
2. In the Preference List Selector activity, **double-click** the preference list you want to edit.


Hyperspace - TRN AMB SPECIALTY CL - Training - PAT C.
Epic
Chart
Telephone Call
Orders Only
Refill Medication
Follow-up
My Reports
Remind Me
Print
Log Out
Workbench
Preference List Selector
PrefList Selector
ID
Name
19776 CEZANNE, PAT'S (4345) BESTPRACTICE PREFERENCE IP
19775 CEZANNE, PAT'S (4345) BESTPRACTICE PREFERENCE OP
19784 CEZANNE, PAT'S (4345) BULK ORDERS PREFERENCE IP
19783 CEZANNE, PAT'S (4345) BULK ORDERS PREFERENCE OP
19770 CEZANNE, PAT'S (4345) EDUCATION PREFERENCE IP
19769 CEZANNE, PAT'S (4345) EDUCATION PREFERENCE OP
19758 CEZANNE, PAT'S (4345) EKG PREFERENCE IP
19757 CEZANNE, PAT'S (4345) EKG PREFERENCE OP
19778 CEZANNE, PAT'S (4345) HAIKU MEDICATIONS PREFERENCE IP
19777 CEZANNE, PAT'S (4345) HAIKU MEDICATIONS PREFERENCE OP
19756 CEZANNE, PAT'S (4345) IMAGING PREFERENCE IP
19755 CEZANNE, PAT'S (4345) IMAGING PREFERENCE OP
19760 CEZANNE, PAT'S (4345) IMMUNIZATIONS PREFERENCE IP
19759 CEZANNE, PAT'S (4345) IMMUNIZATIONS PREFERENCE OP
19754 CEZANNE, PAT'S (4345) LABS PREFERENCE IP
19753 CEZANNE, PAT'S (4345) LABS PREFERENCE OP
19780 CEZANNE, PAT'S (4345) MEDICATIONS PREFERENCE IP
19779 CEZANNE, PAT'S (4345) MEDICATIONS PREFERENCE OP
19774 CEZANNE, PAT'S (4345) NURSING ORDERS PREFERENCE IP
19773 CEZANNE, PAT'S (4345) NURSING ORDERS PREFERENCE OP

The Choose Contact window displays.

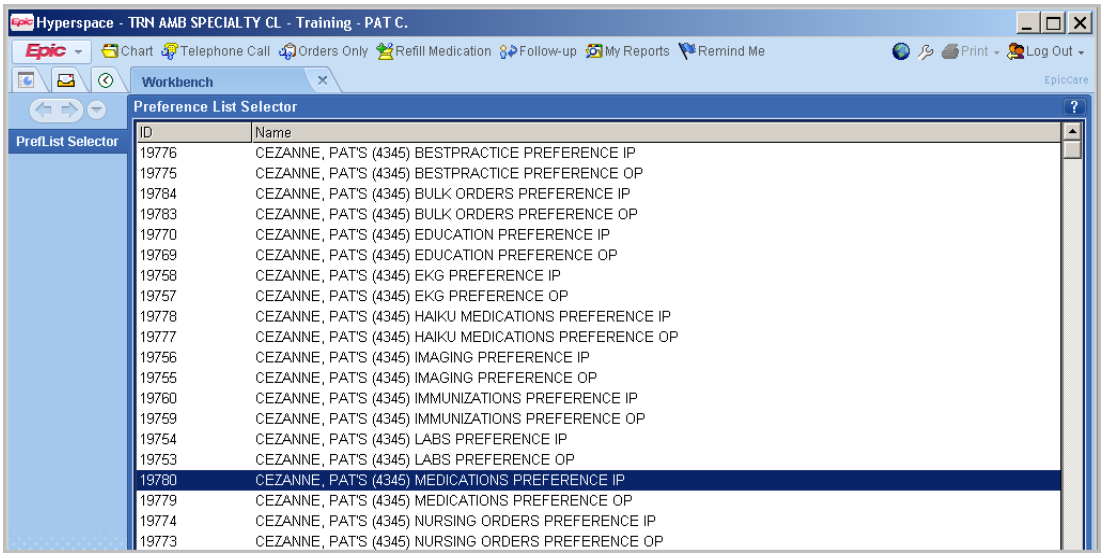
3. Select the most recent record and click **Accept**. The PrefList Composer activity displays.
4. From the Preference List Sections area, select the section to edit.
5. From the right-hand area, **double-click** the item to edit (or select it and click **Edit Details**). The Preference List Defaults window displays.



6. Update the details as required.
7. When you are done, click **Accept**. The updated item is now available on your personal preference list.

REMOVE AN ITEM FROM YOUR PERSONAL PREFERENCE LIST

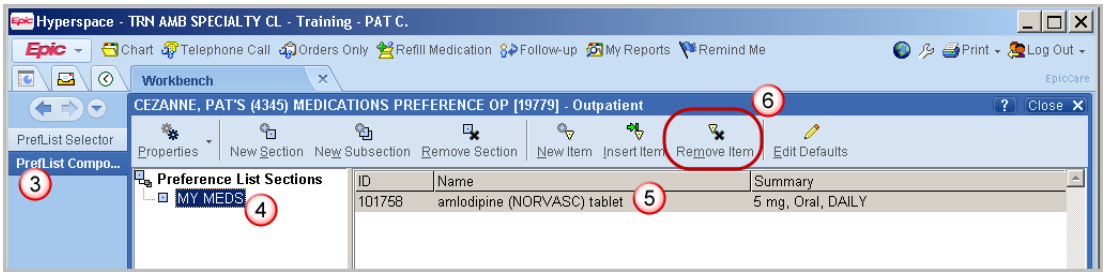
1. Select **Epic button > Tools > Preference List Composer**. The PrefList Selector activity displays in a new workspace.
2. In the Preference List Selector activity, **double-click** the preference list you want to delete.


Hyperspace - TRN AMB SPECIALTY CL - Training - PAT C.
Epic
Chart
Telephone Call
Orders Only
Refill Medication
Follow-up
My Reports
Remind Me
Print
Log Out
Workbench
PrefList Selector
Preference List Selector
ID
Name
19776 CEZANNE, PAT'S (4345) BESTPRACTICE PREFERENCE IP
19775 CEZANNE, PAT'S (4345) BESTPRACTICE PREFERENCE OP
19784 CEZANNE, PAT'S (4345) BULK ORDERS PREFERENCE IP
19783 CEZANNE, PAT'S (4345) BULK ORDERS PREFERENCE OP
19770 CEZANNE, PAT'S (4345) EDUCATION PREFERENCE IP
19769 CEZANNE, PAT'S (4345) EDUCATION PREFERENCE OP
19758 CEZANNE, PAT'S (4345) EKG PREFERENCE IP
19757 CEZANNE, PAT'S (4345) EKG PREFERENCE OP
19778 CEZANNE, PAT'S (4345) HAIKU MEDICATIONS PREFERENCE IP
19777 CEZANNE, PAT'S (4345) HAIKU MEDICATIONS PREFERENCE OP
19756 CEZANNE, PAT'S (4345) IMAGING PREFERENCE IP
19755 CEZANNE, PAT'S (4345) IMAGING PREFERENCE OP
19760 CEZANNE, PAT'S (4345) IMMUNIZATIONS PREFERENCE IP
19759 CEZANNE, PAT'S (4345) IMMUNIZATIONS PREFERENCE OP
19754 CEZANNE, PAT'S (4345) LABS PREFERENCE IP
19753 CEZANNE, PAT'S (4345) LABS PREFERENCE OP
19780 CEZANNE, PAT'S (4345) MEDICATIONS PREFERENCE IP
19779 CEZANNE, PAT'S (4345) MEDICATIONS PREFERENCE OP
19774 CEZANNE, PAT'S (4345) NURSING ORDERS PREFERENCE IP
19773 CEZANNE, PAT'S (4345) NURSING ORDERS PREFERENCE OP

The Choose Contact window displays.

3. Select the most recent record and click **Accept**. The PrefList Composer activity displays.
4. From the Preference List Sections area, select the appropriate section.
5. From the right-hand section, select the item.

6. From the activity toolbar, click **Remove Item**.



A confirmation window displays.

7. Click **Yes**. The item no longer displays on your personal preference list.

MANAGE PERSONAL PREFERENCE LISTS CREATED USING BROWSER AND COMPOSER

As previously discussed, the Preference List Browser displays a combination of orders built for your specialty as well as your personalized orders.

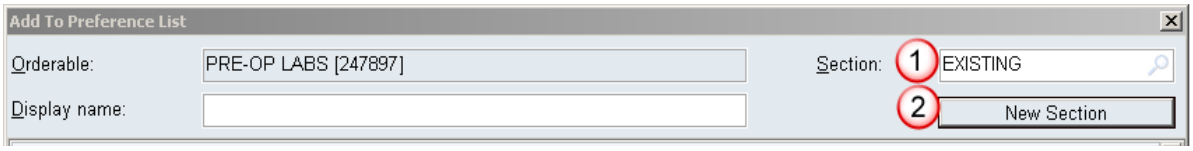
There are several things you should note when personal preference lists are built using both the Preference List Composer and the Preference List Browser.

During a patient encounter, you do not have the ability to ***directly*** add your personalized order to the appropriate specialty built or personalized sections of the Preference List Browser.

When you mark an order as a favorite from a patient encounter, the order can be placed ***only*** in the Orders ***system*** preference list.

① In the Orders system preference list, the Existing section is automatically created for you.

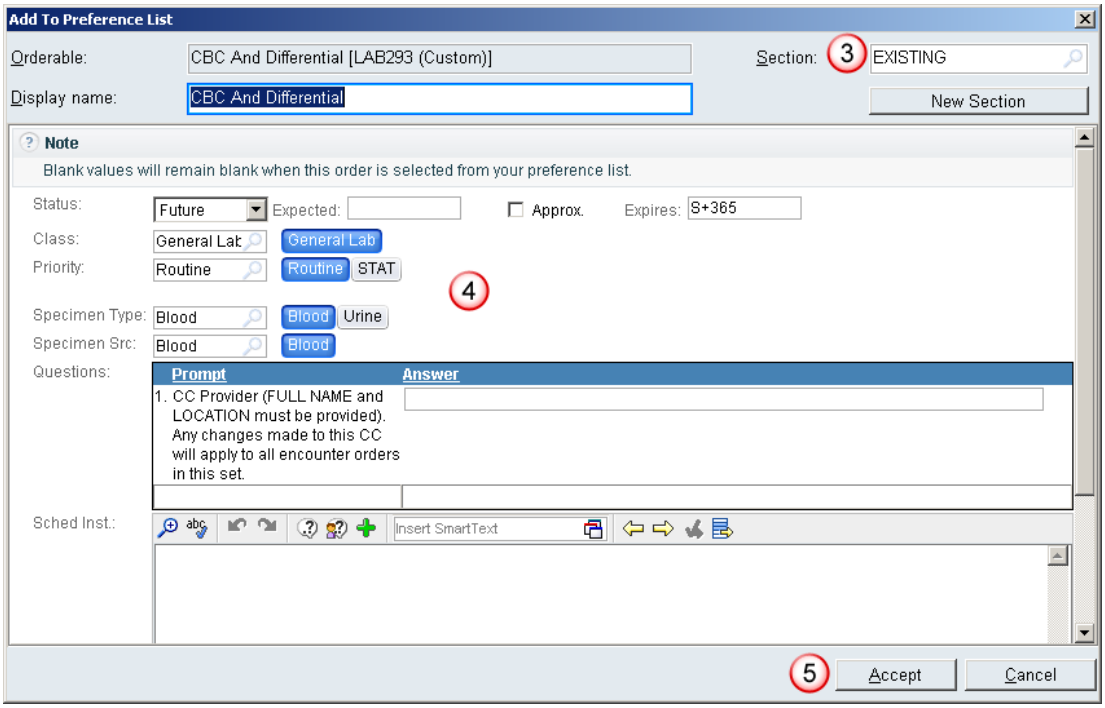
② You have the option of creating a new section but this new section still resides on the Orders system preference list.



Only create a New Section in the Orders system preference list if your intention is to keep all personalized orders in this area.

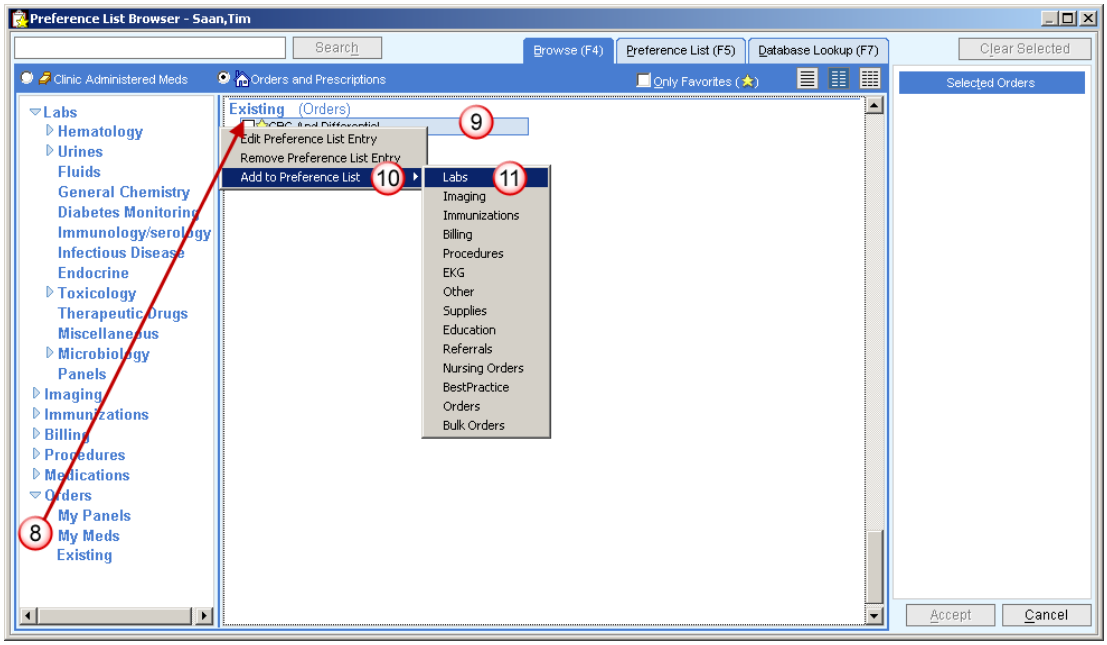
If your intention is to have all of your personalized orders display in the appropriate specialty-built or previously built personalized sections of the Preference List Browser, then you need to perform these additional steps.

1. From the navigator table of contents, access the Meds & Orders section.
2. Place an order and click the star beside it. The Add to Preference List window displays.
3. Leave the section name as Existing.
4. Complete the details for your personalized order.
5. When you are done, click **Accept**, to close the window.



6. Click Keep Order. The Meds & Orders section redisplays.
7. To view this order, in the Preference List Browser, click **New Order**.
8. Locate the order that you just placed under the **Orders > Existing** section.

   From the Preference List Browser you cannot directly move your personal order from one section to another. You can, however, copy the order from the Existing section to the appropriate specialty built or personalized section.
9. **Right-click** the personal order.
10. Select Add to Preference List.
11. Select the appropriate system preference list. Note that you cannot see the names of your specialty or personalized sections in this list at this time.



The Add to Preference List window redisplays giving you another opportunity to make any adjustments to the order details.

Remember that you are now in the appropriate system preference list.

12. Perform either step 12a or 12b or 12c.

    A. To add your personalized order to an ***existing specialty built section***, perform the following:

        i. Click **New Section**. The New Section window displays.

        ii. Type the name of the existing specialty section in the Display Name. (Note that when the system compiles the orders to display in the specialty section, it will create a list of the existing specialty orders and personalized orders).

    B. To add your personalized order to a ***new personalized section*** in the system preference list, perform the following:

        i. Click **New Section**. The New Section window displays.

        ii. Type the name of the new personalized section in the Display Name.

    C. To add your personalized order to an ***existing personalized section*** within the system preference list, perform the following:

        i. From the **Section** field, click the Selection Tool. The Item Select window displays.

        ii. Select the appropriate name of the personalized section and click **Accept**.

        iii. When you are done, click **Accept**.

13. You now need to delete the personalized order from the Orders > Existing section.

14. From the Existing section, select the order that needs to be deleted.
15. Right-click and select ***Remove from Preference List Entry***. A deletion confirmation window displays. To confirm the deletion, click **Yes**. The order is removed from the Existing section.

MANAGE PERSONAL SMARTPHRASES

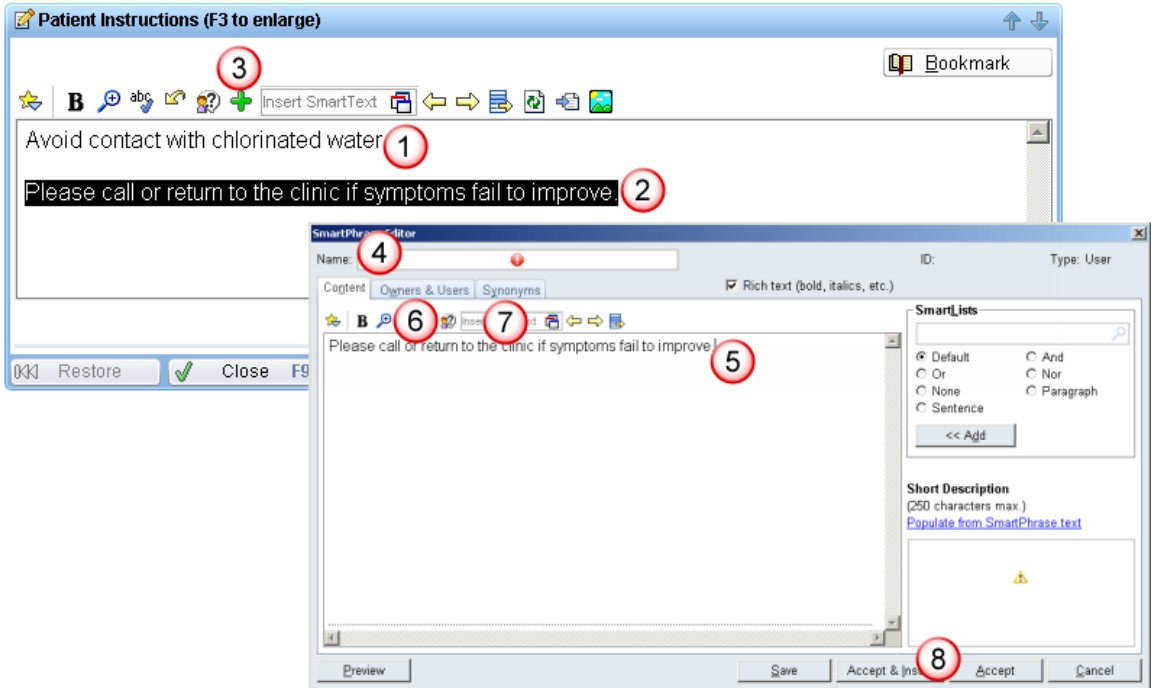
SmartTool is the name used to describe a series of tools that assist you with making the charting process faster. SmartTools include SmartLinks, SmartLists, SmartPhrases, SmartText and SmartSets. Of all the SmartTool types, users are able to create only personal SmartPhrases.

To decide what text would make a useful SmartPhrase, watch for sentences, fragments, or even words that you commonly use.

CREATE A PERSONAL SMARTPHRASE – DURING AN ENCOUNTER

Building your own personal SmartPhrases takes very little time and can drastically speed up your workflow.

1. In a SmartTool-enabled text box, type the text of your SmartPhrase.



2. Highlight the text.
3. Click (**Create SmartPhrase**) on the SmartTool-enabled toolbar. (You can also right-click and select **SmartPhrase > Create SmartPhrase from Selected Text**). The SmartPhrase Editor window displays with the text you selected appearing in the SmartPhrase Text field.
4. In the **Name** field, type a name for your SmartPhrase.

TIP: We strongly recommend that you add your initials to the beginning of all the SmartPhrases that you create. This will help you to distinguish your SmartPhrases from others.

5. Make any necessary edits to your phrase.
6. To share your personal SmartPhrase with others, select the Owners/Users tab.

Owners vs Users

- **Owners** are users who can edit a SmartPhrase. To grant other users the ability to edit your SmartPhrase, add their name(s) to the SmartPhrase Owners area.
- **Users** can use the SmartPhrase but are not able to edit it. To grant other users the ability to use your SmartPhrase, add their name(s) to the SmartPhrase Users area.

7. To enable look up of the SmartPhrase using alternate names, select the Synonym tab and add the new entries.
8. Click **Accept**. The SmartPhrase is now available for your use.

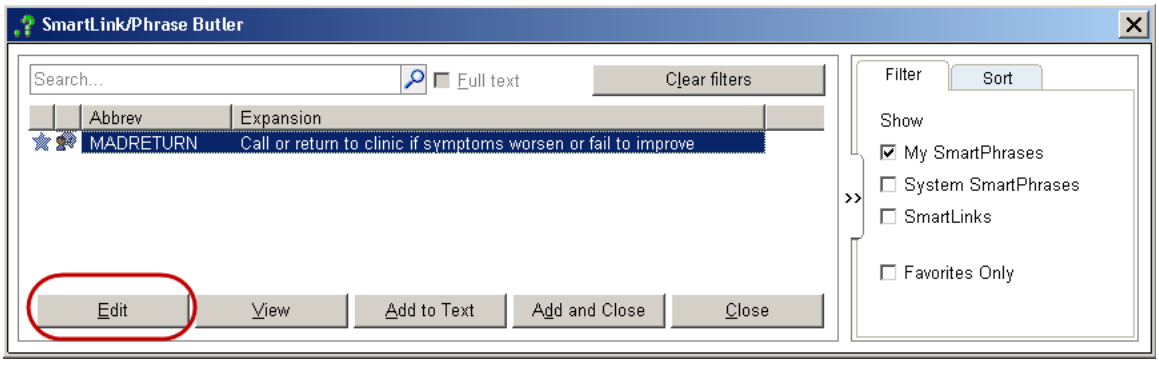
EDIT A PERSONAL SMARTPHRASE – DURING AN ENCOUNTER

Use the SmartLink/Phrase Butler to edit your personal SmartPhrases.

1. Access the SmartLink/Phrase Butler from a SmartTool-enabled text box.
2. From the SmartTool toolbar, click (**List my phrases**). The SmartLink/Phrase Butler displays.
3. Select the appropriate personal SmartPhrase

TIP: If you add a synonym to your personal SmartPhrase, the SmartPhrase Butler displays the synonym as if it were another personal SmartPhrase.

4. Click **Edit**.



The SmartPhrase Editor activity opens in a new workspace.

5. Edit your SmartPhrase as required and then click **Accept**.

CHANGE A SYSTEM SMARTPHRASE INTO A PERSONAL SMARTPHRASE – DURING AN ENCOUNTER

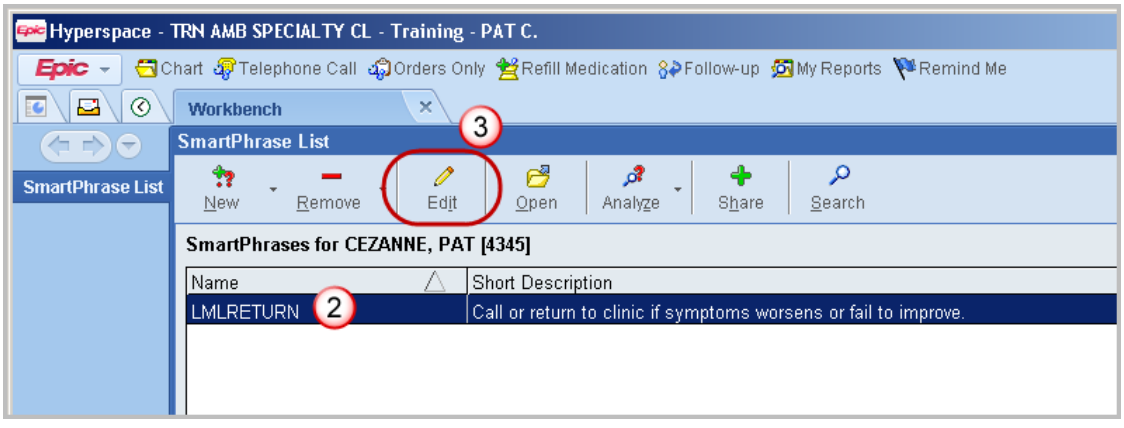
During an encounter you have the ability to take a system SmartPhrase, modify it and then save it as a personal SmartPhrase.

1. Summon a system SmartPhrase.
2. With the system SmartPhrase displayed in a SmartTool-enabled text box, highlight the text and click (**Create SmartPhrase**). You can also **right-click** and select **SmartPhrase > Create SmartPhrase from Selected Text**. The SmartPhrase Editor window displays with the text you selected appearing in the SmartPhrase Text field.
3. Make any necessary edits to the phrase.
4. In the **Name** field, type a name for your personal SmartPhrase.
5. Click **Accept**. The SmartPhrase is now available for your use.

EDIT A PERSONAL SMARTPHRASE - OUTSIDE OF AN ENCOUNTER

Outside of an encounter you also have the ability to modify a system SmartPhrase and save it as a personal SmartPhrase.

1. Select **Epic button > Tools > My SmartPhrases**. The SmartPhrase List activity displays in a new workspace.
2. Select the phrase you want to edit.
3. From the SmartPhrase List activity toolbar, click **Edit**. The SmartPhrase Editor activity displays.

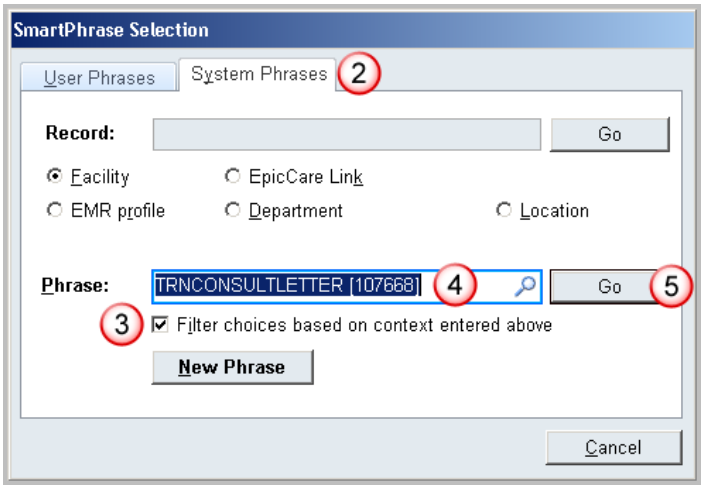


4. Edit your SmartPhrase as required.
5. When you are done, click **Accept**.

CHANGE A SYSTEM SMARTPHRASE INTO A PERSONAL SMARTPHRASE - OUTSIDE OF AN ENCOUNTER

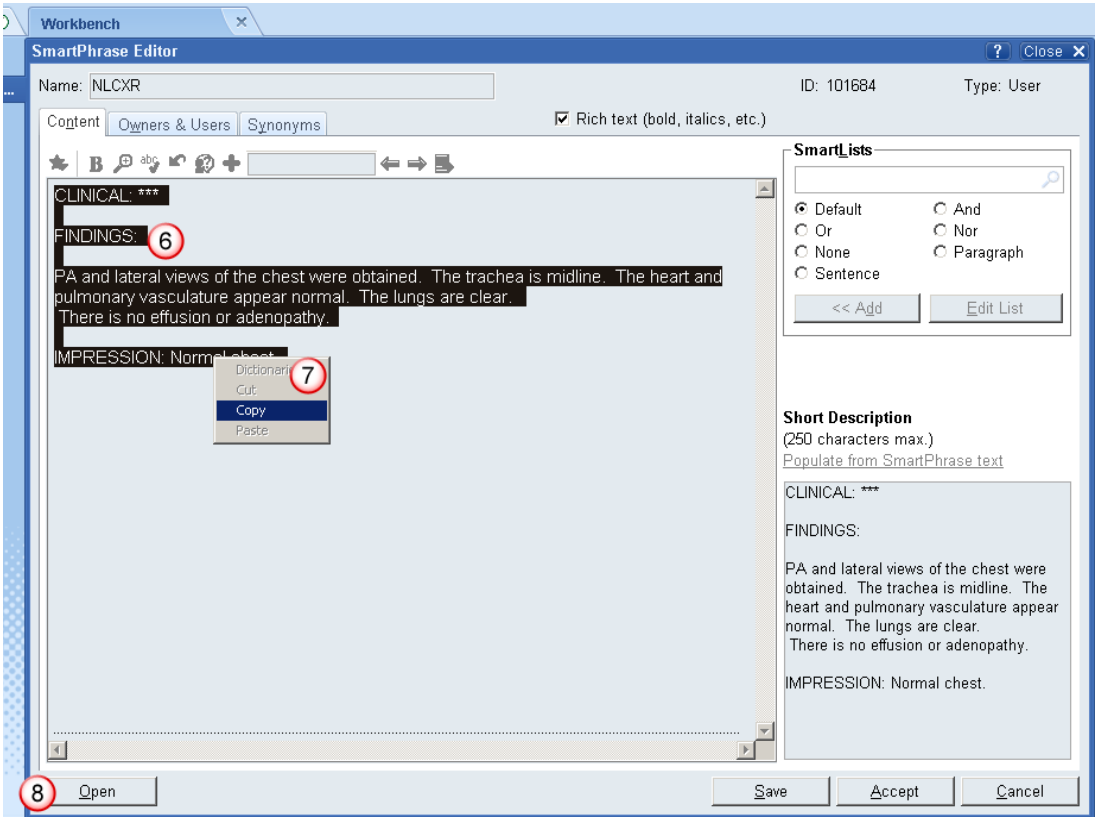
The SmartPhrase Selection window allows you to access the SmartPhrase Editor activity where you can view and edit user and system SmartPhrases.

1. Select **Epic button > Tools > SmartPhrase Manager**. The SmartPhrase Selection window displays.
2. Select the System Phrases tab.
3. To make the search for the system SmartPhrase easier, deselect the ***Filter choices based on context entered above*** option.
4. In the **Phrase** field, use completion matching or click the **Selection** tool to find the system SmartPhrase you want to work with.
5. To view the system SmartPhrase, click **Go**.



The SmartPhrase Editor activity displays in a new workspace. Notice that the text window is greyed out. This indicates that you do not have the ability to edit a system SmartPhrase. You do, however, have the ability to copy it.

6. From the Content tab, highlight the text you want to bring over to your personal SmartPhrase.
7. **Right-click** and from the menu, select Copy.
8. From the bottom of the activity, click **Open**.

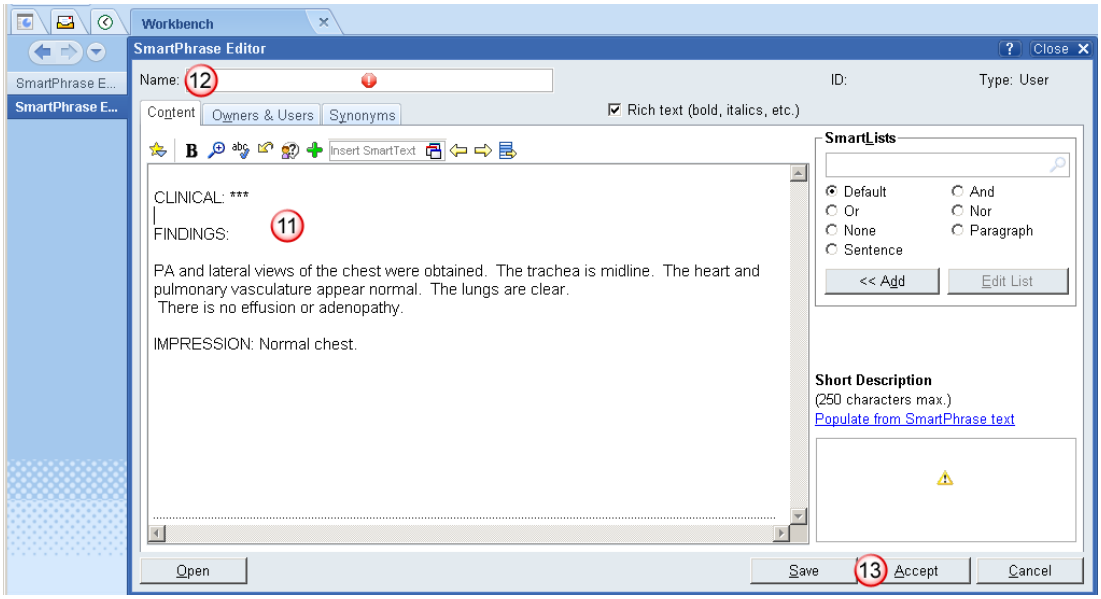


The SmartPhrase Selection window redisplays.

9. To create your new personal SmartPhrase, click **New Phrase**. The SmartPhrase Editor activity redisplays.
10. On the Content tab, in the blank SmartTool-enabled text box, **right-click** and select Paste to finish copying the text.
11. Make any necessary edits to your phrase.
12. In the **Name** field, type a name for your SmartPhrase.

    TIP: We strongly recommend that you add your initials to the beginning of all the SmartPhrases that you create. This will help you to distinguish your SmartPhrases from others.

13. Click **Accept**. The SmartPhrase is now available for your use.



ADD A CHECKBOX TO A PERSONAL SMARTPHRASE - MICROSOFT® OFFICE WORD 2003

You can use personal SmartPhrases to create assessment tools that include ***clickable*** checkboxes. The key is to build your assessment tool in Microsoft® Office Word first and then paste into any SmartTool-enabled area of ***e*CLINICIAN - EMR** and save it as a personal SmartPhrase.

The following are instructions for Microsoft® Office Word 2003.

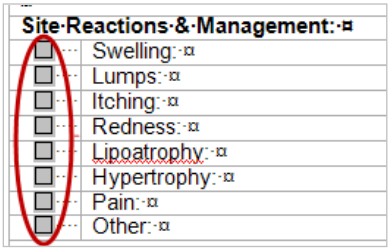
1. Open a new document in Word.
2. Select **View menu > Toolbars > Forms**. The Forms displays.

3. Create your assessment tool.

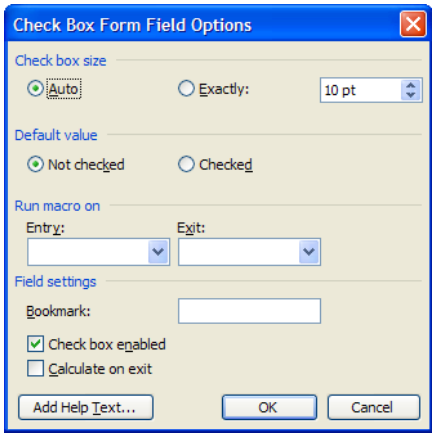
Site·Reactions·&·Management:·¤	
·····	Swelling:·¤
·····	Lumps:·¤
·····	Itching:·¤
·····	Redness:·¤
·····	Lipoatrophy:·¤
·····	Hypertrophy:·¤
·····	Pain:·¤
·····	Other:·¤

4. In the document, click where you want to insert the checkbox.
5. Click the checkbox icon on the Forms toolbar.

A ***clickable*** checkbox displays in your document.



6. To change any of the properties of the checkbox, **double-click** the checkbox to open the Check Box Form Field Options window.
7. Make any necessary changes and click **OK**.



8. When you assessment tool is complete, paste your document into any SmartTool-enabled textbox in ***e*CLINICIAN - EMR** and save it as a personal.

ADD A CHECKBOX TO A PERSONAL SMARTPHRASE - MICROSOFT® OFFICE WORD 2007

You can use personal SmartPhrases to create assessment tools that include ***clickable*** checkboxes. The key is to build your assessment tool in Microsoft® Office Word first and then paste into any SmartTool-enabled area of ***e*CLINICIAN - EMR** and save it as a personal SmartPhrase.

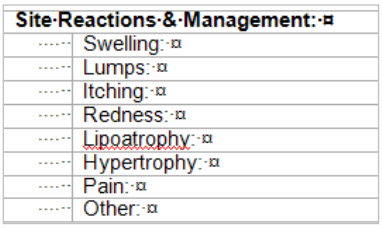
In order to add a checkbox to a Microsoft® Office Word 2007 document, you must first ensure that you have the Developer option in the Ribbon toolbar.

To setup the Developer option in the Ribbon toolbar, perform the following:

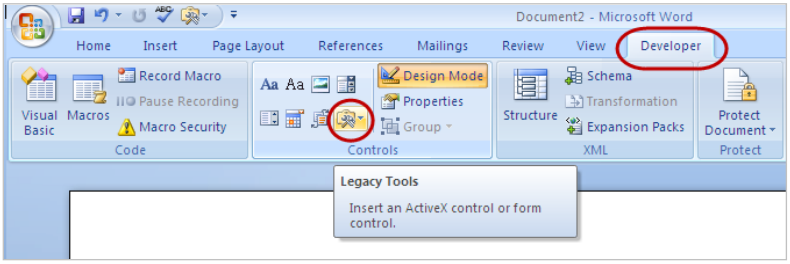
- Click the **Microsoft Office** button, and then click **Word Options**.
- Click **Popular**.
- Select the Show Developer tab in the Ribbon check box, and then click **OK**.

The following are instructions for Microsoft® Office Word 2007.

1. Open a new document in Word.
2. Create your assessment tool and place your cursor where you want to insert a checkbox.

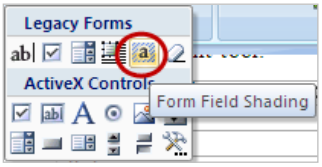


3. Select Developer tab > Controls group> Legacy Tools.

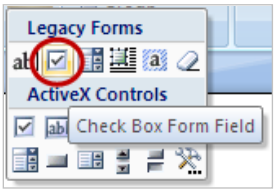


The Legacy Forms options display.

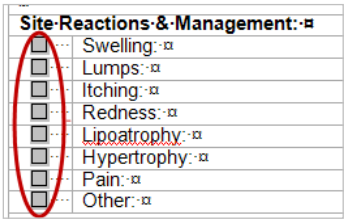
4. Optional step: If you do not want the checkboxes to be shaded, click the **Form Field Shading** button.



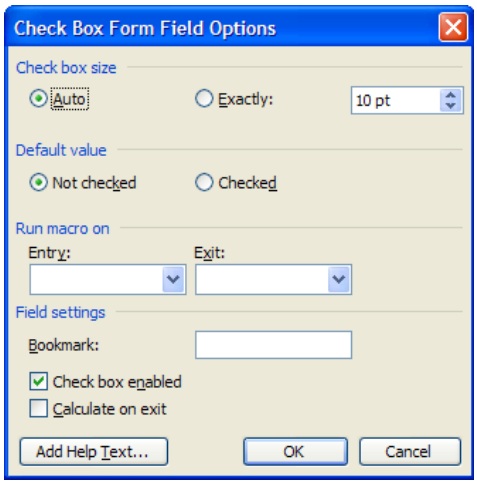
5. To insert the checkbox, click the **Legacy Forms** button; then click the **Check Box Form Field** button.



A ***clickable*** checkbox displays in your document.



6. Optional: To make any changes to the behaviour of the checkboxes, **double-click** them to open the Check Box Form Field Options window. Make any necessary changes and click **OK**.



7. When you assessment tool is complete, paste your document into any SmartTool-enabled textbox in ***e*CLINICIAN - EMR** and save it as a personal SmartPhrase.

DETERMINE WHICH SMARTLINK TO USE IN YOUR SMARTPHRASE

SmartLinks can be especially useful when creating personal SmartPhrases because they allow you to pull patient information into your documentation.

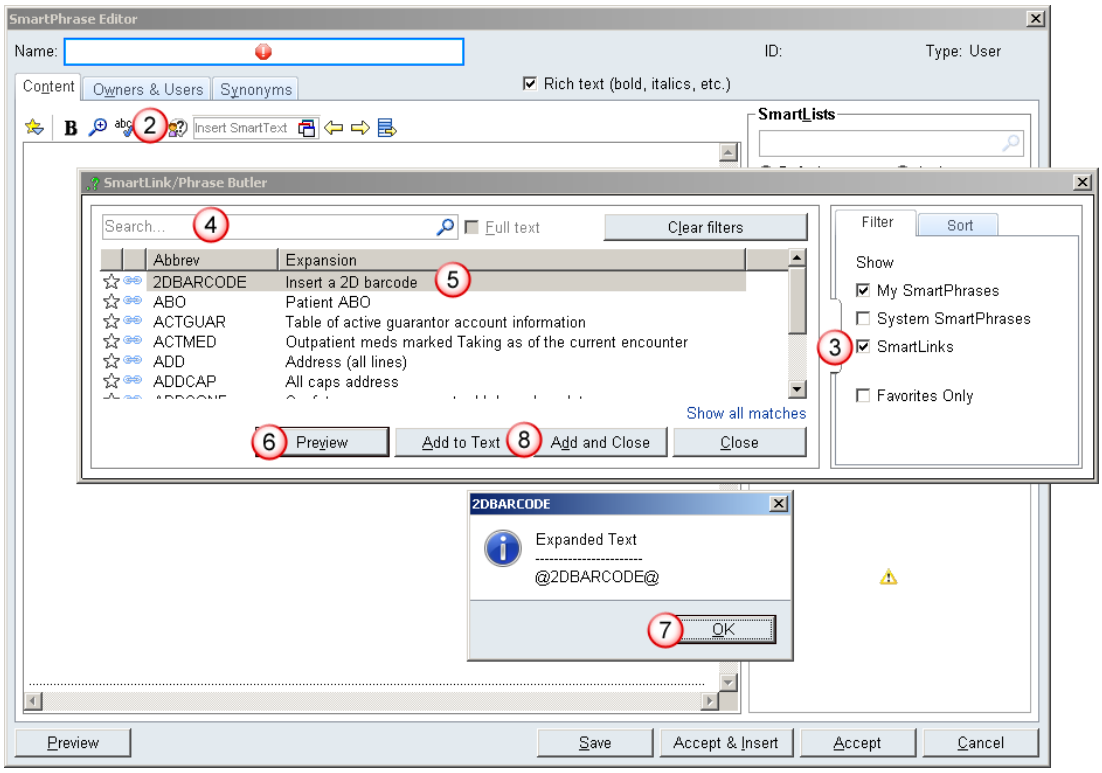
The SmartLink/Phrase Butler, available from the SmartPhrase Editor activity, provides you with the ability to search for the appropriate SmartLink.

1. In a SmartTool-enabled text box, click (**Create SmartPhrase**). The SmartPhrase Editor displays.
2. From the toolbar, click the List My Phrases button. The SmartLink/Phrase Butler displays.
3. From the Filter tab on the right-hand side, select the SmartLinks option and deselect any other selections not needed for your search.
4. In the **Search** field, enter your search criteria, for example, ***allergy*** and press **ENTER**. (Note: The use of plurals can impact the number of results returned). The list of available SmartLinks that matched your search criteria displays.
5. Select a SmartLink.
6. To view the SmartLink name as it should display in the SmartPhrase Editor, click **Preview**. A pop-up window displays showing the formatted SmartLink name (Notice the arroba symbols that surround the name).
7. Click **OK**.

8. Once you have found the appropriate SmartLink, either click:
   - Add to Text and continue searching for additional SmartLinks, or
   - Add and Close, to return to your documentation.

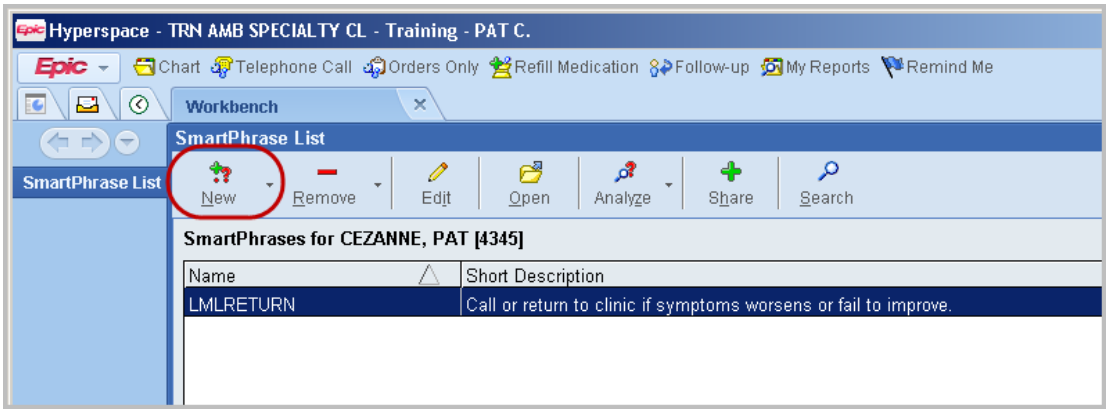
TIP 1: To quickly identify the SmartLinks most helpful to you, click the star to the left of the SmartLink to mark it as a favorite.

TIP 2: For a list of commonly used SmartLinks, refer to **Appendix C: Useful SmartLinks**.



CREATE A PERSONAL SMARTPHRASE - OUTSIDE OF AN ENCOUNTER

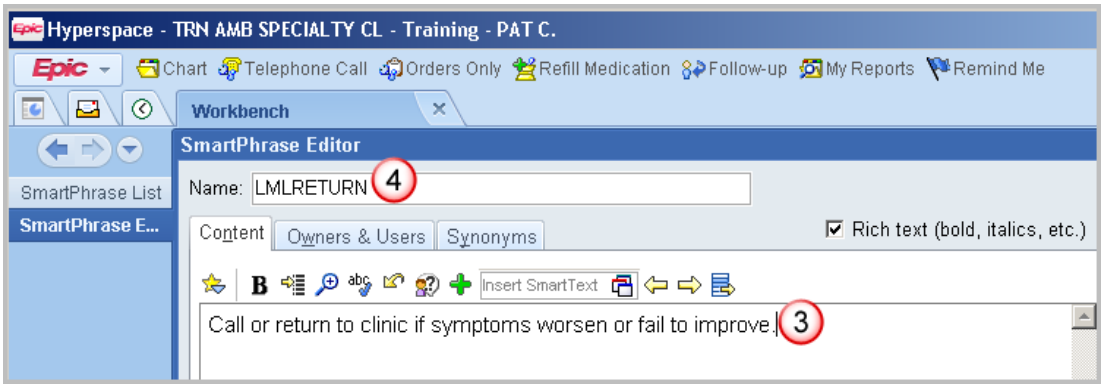
1. Select **Epic button > Tools > My SmartPhrases**. The SmartPhrase List activity displays in a new workspace.
2. From the SmartPhrase List activity toolbar, click **New**.



The SmartPhrase Editor activity displays.

3. On the Content tab, type your personal SmartPhrase.
4. In the **Name** field, type a name for your SmartPhrase.

TIP: We strongly recommend that you add your initials to the beginning of all the SmartPhrases that you create. This will help you to distinguish your SmartPhrases from others.



5. When you are done, click **Accept**. The SmartPhrase is now available for your use.

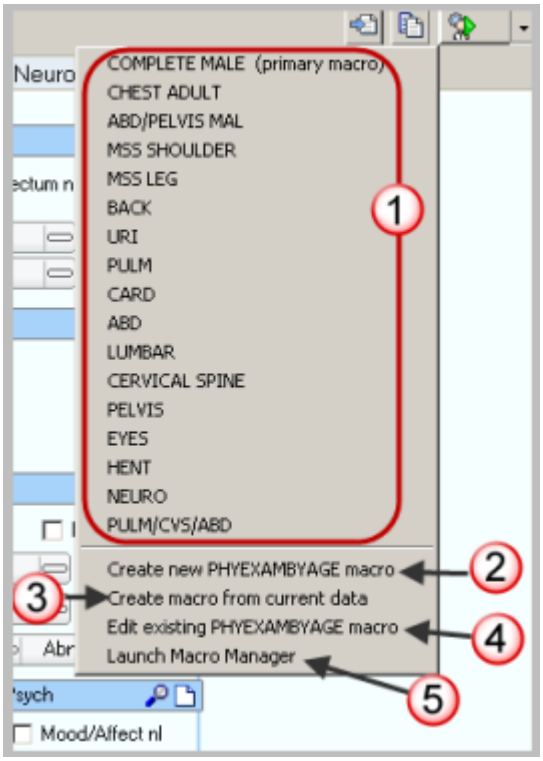
MANAGE SMARTBLOCK MACROS

The creation of SmartBlock macros is one way that you can drastically reduce the time it takes to document progress notes for routine exams.

When you create a SmartBlock macro for a routine examination, the macro remembers the buttons and checkbox selections that you make. When you load the NoteWriter macro the next time you perform this type of exam, all of your defaulted selections automatically display. Any new findings that you have already noted are not overwritten when you load the macro.

As a reminder, SmartBlock Macros are created using the down arrow on the far right of the NoteWriter toolbar. Macros are only available for ROS and the Physical Exam NoteWriter forms.

The Macro menu has the following options:



① List of your macros or macros that others have shared with you.

② Create a new macro for the type of SmartBlock you are currently viewing.

③ Create a macro for the type of SmartBlock you are currently viewing using the findings that are currently documented.

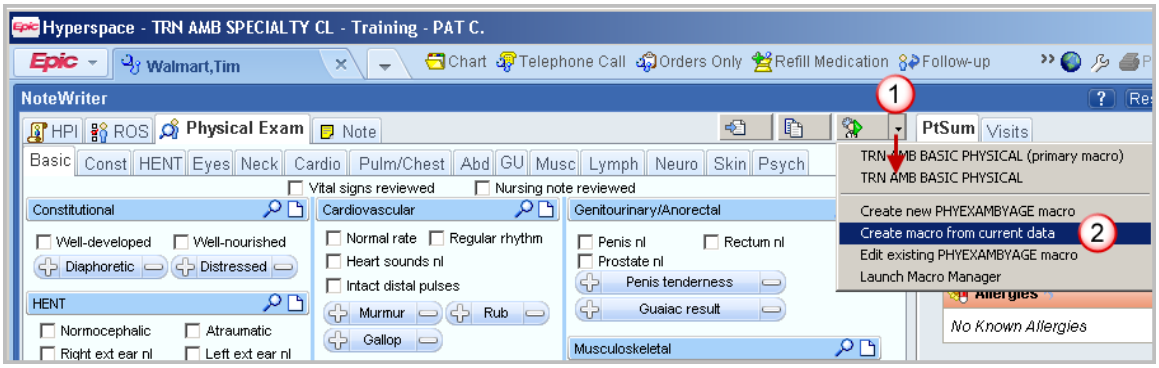
④ Edit an existing macro for the type of SmartBlock you are currently viewing.

⑤ Open the Macro Manager activity.

CREATE A SMARTBLOCK MACRO FROM CURRENT PROGRESS NOTE

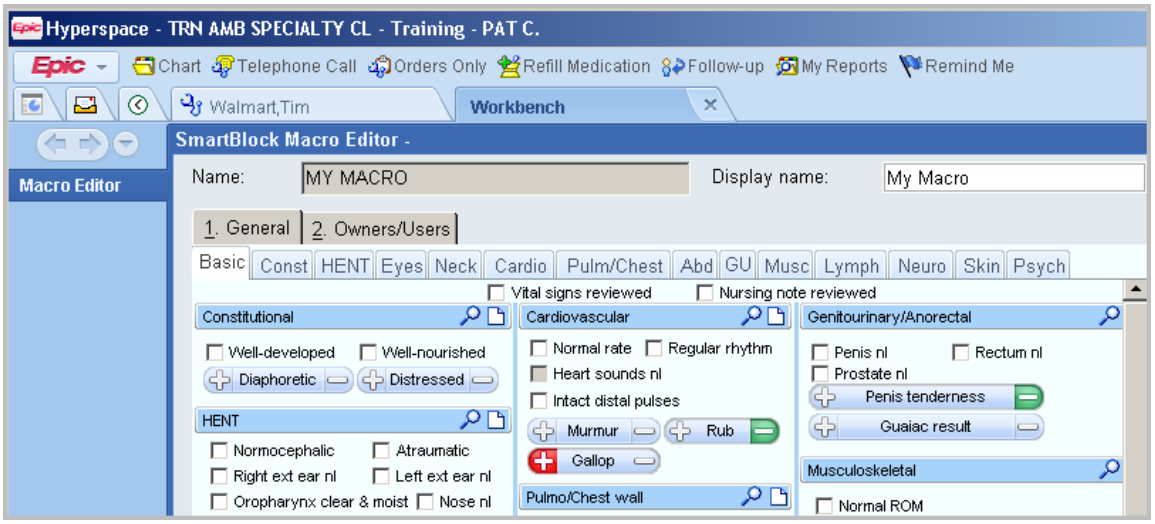
Once you have created a portion of your progress note using either the ROS form or the Physical Exam form, you have the option of saving the buttons and checkbox selections as a SmartBlock macro. The example below involves the Physical Exam form in NoteWriter.

1. From the Physical Exam form in NoteWriter, on the far right of the NoteWriter toolbar, click the down arrow. A menu displays.
2. From the menu, select Create macro from current data.



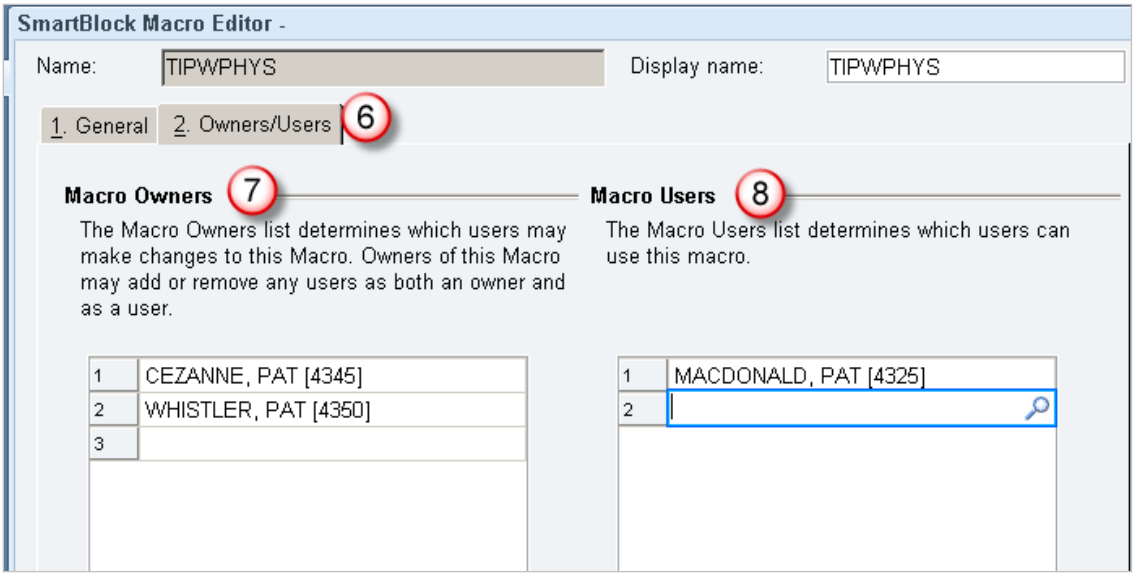
The Macro Selection window displays.

3. In the **Macro** field, type a name for the macro.
4. Click **Accept**. The SmartBlock Macro Editor activity opens in a new workspace displaying a General tab and an Owners/Users tab.
5. On the General tab, revise selections as required.



6. If you want to grant other users the ability to use or to make changes to this macro, select the Owners/Users tab.

7. To grant other users the ability to ***edit*** this macro, in the Macro Owners area, use completion matching to search for the name of the appropriate person(s).
8. To grant other users the ability to ***use*** this macro, in the Macro Users area, use completion matching to search for the name of the appropriate person(s).


SmartBlock Macro Editor -
Name:
TIPWPHYS
Display name:
TIPWPHYS
1. General
2. Owners/Users
6
Macro Owners
7
The Macro Owners list determines which users may make changes to this Macro. Owners of this Macro may add or remove any users as both an owner and as a user.
Macro Users
8
The Macro Users list determines which users can use this macro.
1 CEZANNE, PAT [4345]
2 WHISTLER, PAT [4350]
3
1 MACDONALD, PAT [4325]
2

Sharing SmartBlock Macros

The only restriction to sharing a SmartBlock macro is that the person you share the macro with must also have access to NoteWriter.

You can share your macros with users in your own department and with users in other departments.

TIP: When you use a SmartBlock macro that was changed by the SmartBlock macro owner, a message displays and allows you to accept or cancel out of loading the macro.

9. When you are done, click **Accept**.

Additional Macro Features

If you select the **Set as primary macro** option, this macro becomes the primary macro for this SmartBlock.

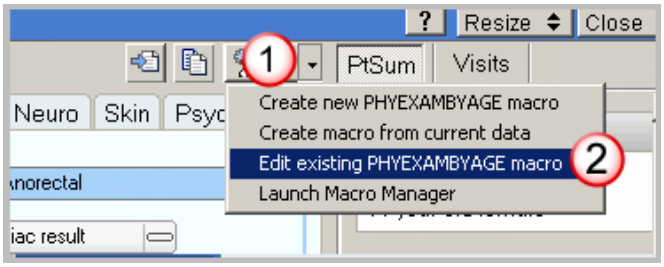
The **Save as** button allows you to make a copy of the macro you just created. You can then open the copy and make the necessary changes.

Note that you **cannot** edit the sex and age restrictions when you copy a macro. For example, if you copy an adult female physical exam macro, you cannot edit it to be an adult male physical exam macro.

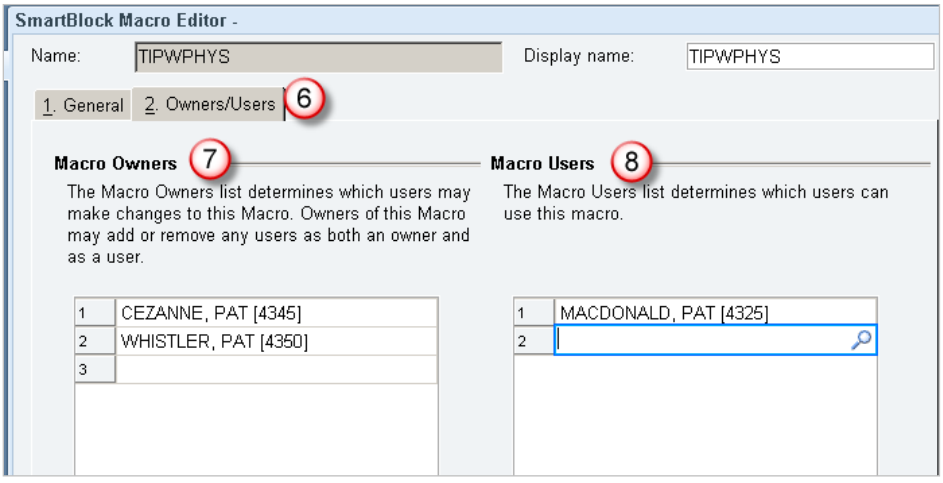
EDIT A SMARTBLOCK MACRO FROM CURRENT PROGRESS NOTE

You can edit an existing macro for the type of SmartBlock you are currently viewing in NoteWriter by performing the following:

10. From either the ROS or Physical Exam form in NoteWriter, on the far right of the NoteWriter toolbar, click the down arrow (the example below involves the Physical Exam form). A menu displays.
11. From the menu, select Edit existing <macro type> macro. In the screenshot below the ***PHYEXAMBYAGE*** (Physical Exam by Age) SmartBlock type is being used.



12. From the Macro Selection window, use completion matching to search for the macro you wish to edit.
13. Click **Accept**. The SmartBlock Macro Editor activity opens in a new workspace displaying a General tab and an Owners/Users tab.
14. On the General tab, make the required revisions.
15. If you would like to add or change the users who have the ability to use or edit your SmartBlock macro, select the Owners/Users tab and make the required revisions.
16. To grant other users the ability to ***edit*** this macro, in the Macro Owners area, use completion matching to search for the name of the appropriate person(s).
17. To grant other users the ability to ***use*** this macro, in the Macro Users area, use completion matching to search for the name of the appropriate person(s).


SmartBlock Macro Editor -
Name:
TIPWPHYS
Display name:
TIPWPHYS
1. General
2. Owners/Users
6
Macro Owners
7
The Macro Owners list determines which users may make changes to this Macro. Owners of this Macro may add or remove any users as both an owner and as a user.
Macro Users
8
The Macro Users list determines which users can use this macro.
1 CEZANNE, PAT [4345]
2 WHISTLER, PAT [4350]
3
1 MACDONALD, PAT [4325]
2

Sharing SmartBlock Macros

The only restriction to sharing a SmartBlock macro is that the person you share the macro with must also have access to NoteWriter.

You can share your macros with users in your own department and with users in other departments.

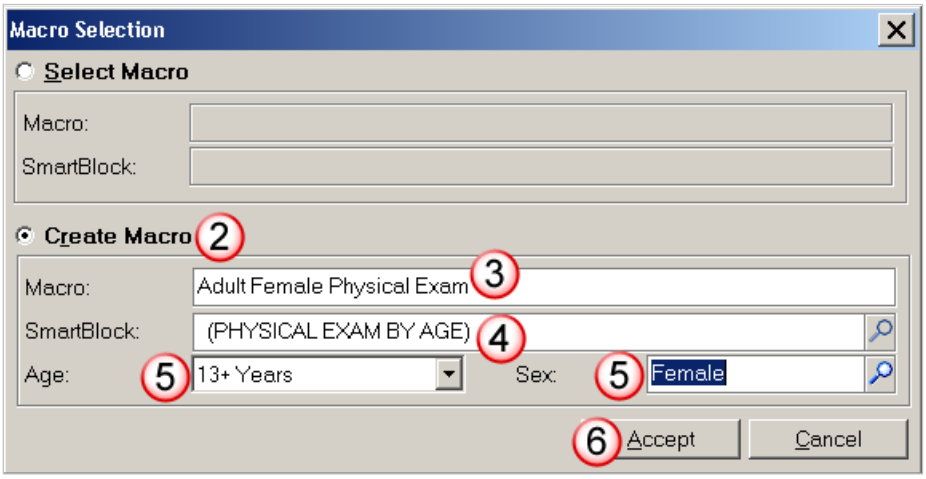
TIP: When you use a SmartBlock macro that was changed by the SmartBlock macro owner, a message displays and allows you to accept or cancel out of loading the macro.

18. When you are done, click **Accept**.

CREATE SMARTBLOCK MACROS – OUTSIDE OF AN ENCOUNTER

SmartBlock Macros can also be created and managed outside of patient encounters.

19. Select **Epic button** > **Tools** > **SmartBlock Macro**. The Macro Selection window displays.
20. Select the Create Macro option.
21. In the **Macro** field, type a descriptive name for the macro (e.g. Adult Female Physical Exam).
22. To create a macro for the Physical Exam form, type ***PHYEXAMBYAGE*** in the **SmartBlock** field. To create a macro for the ROS form, type ***REVIEW_OF_SYSTEMS*** in the SmartBlock field.
23. If you selected the ***PHYEXAMBYAGE*** template, you must enter the appropriate information in the **Age** and **Sex** fields.
24. Click **Accept**. The Macro Editor activity opens in a new workspace.



25. The steps from this point forward are the same as in the topic ***Create a SmartBlock Macro from Current Progress Note.***

EDIT AN EXISTING SMARTBLOCK MACRO – OUTSIDE OF AN ENCOUNTER

Outside of a patient encounter, use the following steps to edit your macros.

1. Select **Epic button > Tools > SmartBlock Macro**. The Macro Selection window displays.
2. Choose **Select macro** and use completion matching to search for the macro you wish to edit.
3. Click **Accept**. The SmartBlock Macro Editor activity opens in a new workspace displaying a General tab and an Owners/Users tab.
4. On the General tab, make the required revisions.
5. If you would like to add or change the users who have the ability to use or edit your SmartBlock macro, select the Owners/Users tab and make the required revisions.
6. To grant other users the ability to ***edit*** this macro, in the Macro Owners area, use completion matching to search for the name of the appropriate person(s).
7. To grant other users the ability to ***use*** this macro, in the Macro Users area, use completion matching to search for the name of the appropriate person(s).

Sharing SmartBlock Macros

The only restriction to sharing a SmartBlock macro is that the person you share the macro with must also have access to NoteWriter.

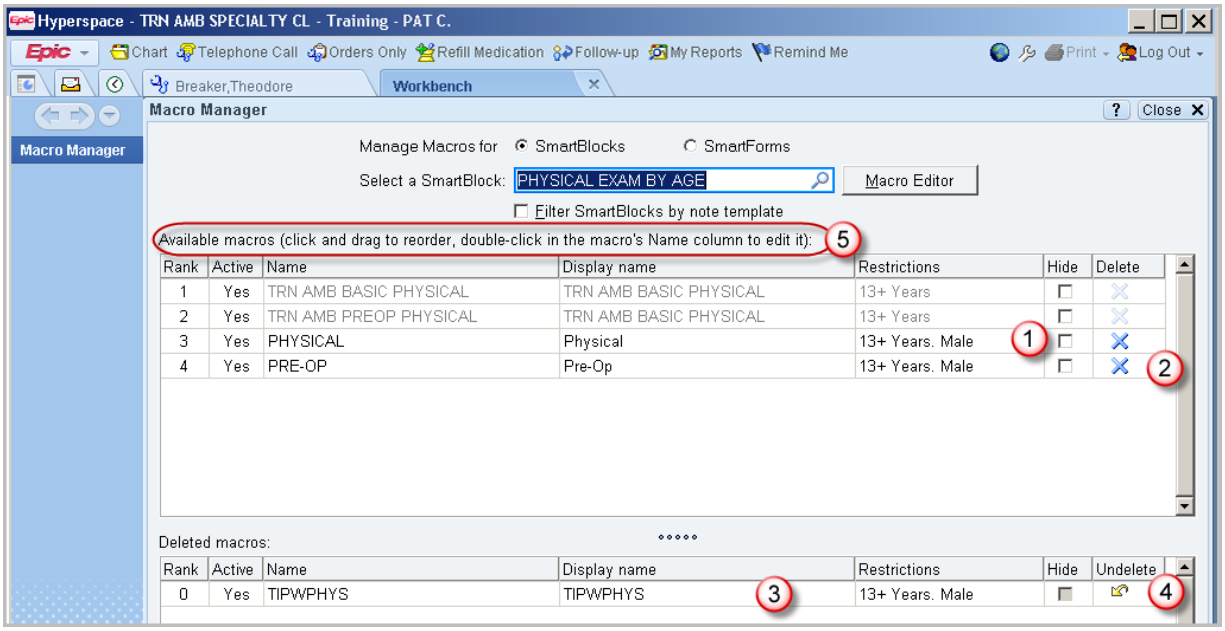
You can share your macros with users in your own department and with users in other departments.

TIP: When you use a SmartBlock macro that was changed by the SmartBlock macro owner, a message displays and allows you to accept or cancel out of loading the macro.

8. When you are done, click **Accept**.

MANAGE YOUR SMARTBLOCK MACROS

The Macro Manager activity is used to manage your SmartBlock macros.



Access the Macro Manager activity the following ways:

- Within an encounter - From NoteWriter, from the drop down menu on the far right of the NoteWriter toolbar.
- Outside of an encounter - From **Epic button > Tools > Macro Manager**.

You can perform the following actions from this activity:

① Hide a shared macro by selecting the checkbox in the appropriate row. This action prevents the macro from displaying in the drop down menu on the far right of the NoteWriter toolbar.

② Delete a macro (that you own) by clicking the **X** in the appropriate row.

③ Deleted macros display in the lower portion of the screen.

④ Bring a deleted macro back by clicking the Undelete icon in the appropriate row.

⑤ Sort macros for each type of SmartBlock (ROS and Physical Exam) by order of importance. To sort, select the appropriate row and drag the macro to the new location.

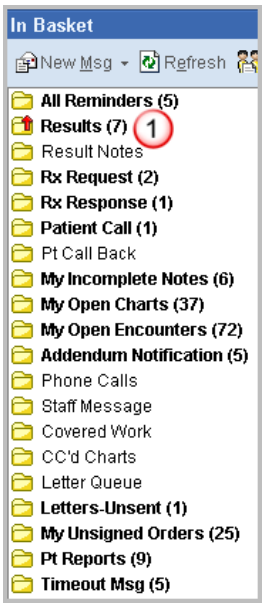
> **TIP**: Once you name a SmartBlock macro you cannot rename it. You can change only the macros **Display Name**. To change the Display Name, **double-click** the **Display Name** field.

PERSONALIZE YOUR IN BASKET

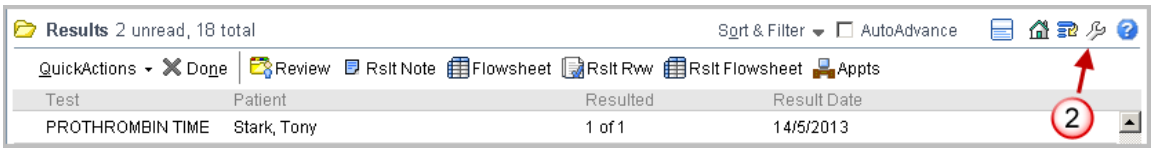
PERSONALIZE MESSAGE COLUMNS

Users can now modify the columns that appear in individual message folders, so that the information displays in the order you prefer.

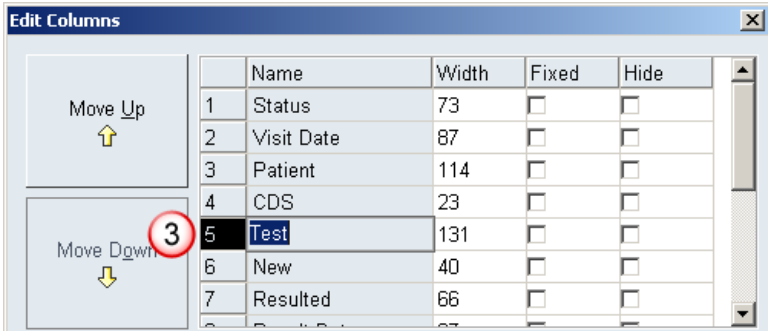
1. Select the folder for which you wish to configure your view.



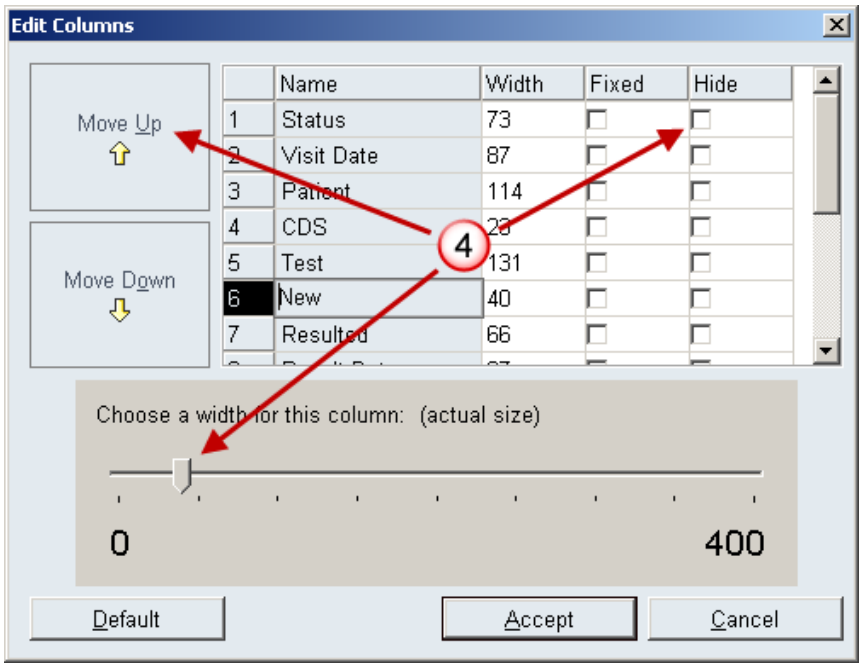
2. On the far right of the Bottom toolbar, click the wrench icon.



3. Select a column to configure by clicking the column name.



4. Customize the column view by using:
   - **Move Up** and **Move Down** buttons to change the order of the message columns.
   - The slider control to adjust column width.
   - Checkboxes under the Hide column to hide or unhide the column.



5. Repeat steps 3 and 4 for each column you wish to configure.
6. When you have finished your configuration, click **Accept**.

TIP: To reveal hidden columns, you can click **Show Hidden Columns** on the Bottom In Basket toolbar Click the button again to re-hide columns.

CREATE QUICKACTIONS

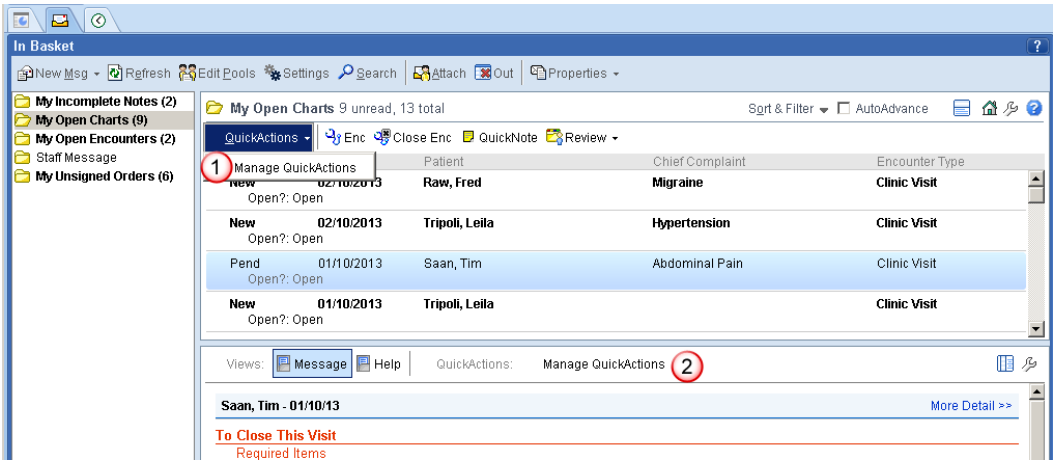
QuickActions are macros for your In Basket; they allow you automate the steps that you would take to deal with various message types. For example you can create a QuickAction that creates a result note containing the desired message and recipients. There are three different QuickActions that can be configured:

- Result Note QuickAction
- QuickNote QuickAction
- Edit Note QuickAction

The QuickActions Manager is where you can create, edit and delete QuickActions. You can access The QuickActions Manager from the In Basket in the following two ways:

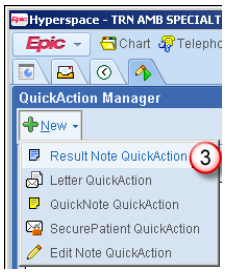
① From the Bottom In Basket toolbar, select **QuickActions > Manage QuickActions**.

② From the Message Report toolbar, click **Manage QuickActions.**



The following example demonstrates building a Result Note QuickAction for abnormal results. The basic steps for the other QuickAction types are similar.

7. From the In Basket, access the Results folder.
8. Access the QuickActions Manager.
9. To create a new Result Note Quick Action, select **New > Result Note QuickAction**. The Result Note QuickAction Editor displays.



The options available in the QuickAction Editor depend on the type of QuickAction you are creating.

10. In the **Button name** field, type a descriptive name for the QuickAction. For example, ***<your initials>Abnormal Results***.

11. To have the system automatically mark the Result message as ***Done*** once you've sent your Result Note message, select the ***Mark In Basket message as complete after filing*** checkbox.

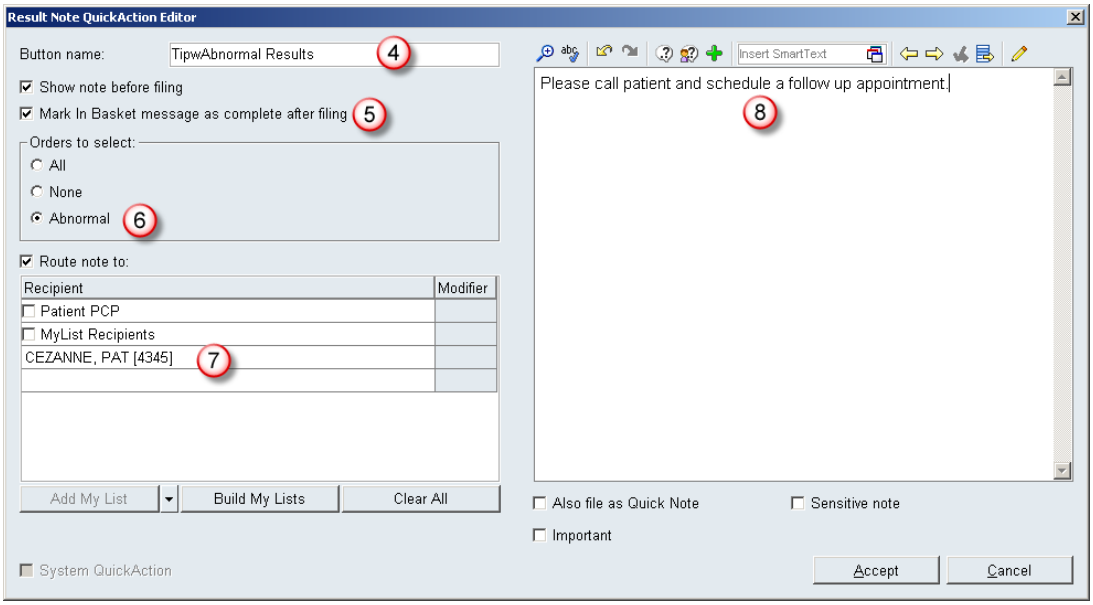
12. In the orders to select area, choose ***Abnormal***.

    This choice ensures that if there are multiple results that are part of a single result message only the abnormal results are selected.

13. Enter an individual, class or pool to receive the message

    TIP: In the clinic you may want to use the pool that was created for admin staff.

14. In the SmartTool-enabled text field, type the message to the recipient(s). This message displays by default, every time you use this QuickAction.



15. To save the QuickAction, click **Accept**. Your new QuickAction appears with the name you assigned under the QuickActions menu in the Bottom In Basket toolbar and as a button on the Message Report toolbar.

If you are in the middle of composing a QuickNote or Result Note and decide that you want to make it into a QuickAction, click the **Save as QuickAction** button on the bottom left of the Result Note or QuickNote window. The corresponding QuickAction Editor displays and you can make the necessary selections as described in the steps above.

APPENDICES

APPENDIX A: FREQUENTLY ASKED QUESTIONS

ABSTRACTION

1. **Where is the pre-loaded information coming from?**

   Existing clinical information in ***e*CLINICIAN** comes from one of three sources:

   - Investigations performed within the Edmonton Zone are interfaced from Netcare (Lab and Radiology). Netcare can be accessed from the desktop or from within ***e*CLINICIAN**.
   - For patients who have been seen in clinics already live with ***e*CLINICIAN**, patient information has been documented, reviewed and ordered electronically.
   - For patients who have not been seen in any live ***e*CLINICIAN** clinics, clinical information is abstracted from the patient's paper chart and some referral / consult letters have been uploaded into the system and are viewable under the "Chart Review" activity, in the "Letters" or "Media" Tab.

   Because the clinical information is only accurate at the time of documentation (electronically or on paper), it is strongly recommended that the patient's allergies, medications, and history are reviewed and confirmed (via "Mark as Reviewed") at every visit.

   It is strongly recommended that Abstracts be reviewed for accuracy at first time of visit.

ALLERGIES

1. **The Allergy I want isn't in the list. What do I do?**

   Be sure the "Full Search" checkbox is selected.

   Use fewer letters when searching (i.e. enter "poll" for pollen, "rag" for ragweed).

   If you still can't find what you're looking for, search for and select ***Other***. In the Comments field identify the allergy. The Comments field is reviewed quarterly and allergies re-occurring most often are added to the discrete list of allergies in the system.

BILLING CODES / FEE FOR SERVICE / ESL (ELECTRONIC SERVICE LOG)

1. **How do I "drop a billing code" for a consult on another provider's scheduled appointment?**

   If a physician is consulted on another provider's scheduled appointment and wants to drop a billing code, request him/her to open an "orders only" encounter.

2. **Can a physician drop a billing code for a telephone call?**

   Yes. Open a telephone encounter, enter diagnosis, enter documentation on advice given or asked, and order a telephone billing code in Meds & Orders.

   If the patient is from a non-EMR live area (i.e. IP / ER) then continue with paper billing for Tele/Advice.

   Note: Billers do not need the name of the physician they called or spoke to.

3. **Electronic Service Log (ESL)**

   ESL can be used for scheduled visits only. For non scheduled visits (telephone encounter, refill encounter, orders only encounter) use the paper service log as before or launch the ESL from a previously scheduled encounter.

   To launch the ESL from a previously scheduled encounter:

   - Click **Chart**.
   - Enter the patient identifiers.
   - Go to the "Encounters" tab of Chart Review.
   - Find the appropriate "Clinic Visit" to associate with the Service Log for this non scheduled visit (Only select encounters with a type of "Clinic Visit").
   - Click on the "Launch Electronic Service Log" link.
   - Enter appropriate services.

DICTATION

1. **I want to dictate a consult letter instead of documenting a progress note. How do I do this?**

   A progress note is required to close an encounter. Therefore, if you choose to dictate a consult letter without a progress note please indicate "see consult letter" in the progress note section so that you can close the encounter.

DOC FLOWSHEETS / REVIEW FLOWSHEETS

1. **The Doc Flowsheet SmartLink isn't working in my telephone encounter documentation section. What do I do?**

   SmartLinks for Flowsheets do not work in a telephone encounter. If you need to use the Flowsheet SmartLinks, use the Orders Only or a telephone encounter.

DRUG COVERAGE

1. **Where do I document drug coverage for my patient?**

   Use the Care Teams Activity to record the Insurance Information. Use the Free Text Provider field to enter the name of the Insurance and use "Other" as the relationship.

   Blue Cross drug authorization claim forms are completed and scanned into the EMR at the patient level.

   Note: You can add a link on your ***e*CLINICIAN** Dashboard to the Blue Cross forms for quick access.

HOME CARE ORDERS / PATIENT CARE ORDERS

1. **How do I place Home Care Orders?**

   These are placed under PCO's – Patient Care Orders.

   PCOs are printed and also filed automatically in Chart Review > Procedures tab.

IN BASKET

1. **How do I communicate with my Secretary or Admin Assistant regarding follow-ups?**

   Before utilizing ***e*CLINICIAN** for communication with your administration staff, discuss the expectations for monitoring the ***e*CLINICIAN** In Basket on a regular basis.

   In a Visit, you can utilize the CC'd Chart in the Follow Up section to provide direct communication to your administration staff regarding any follow-ups. They will receive this message in their In Basket under the CC'd Charts folder.

   If the patient is not present, a staff message can be utilized to request specific follow-up from your administration staff. In addition, staff messages can provide flags to separate out the different actions you are requesting of your administration staff and you can set due dates for the task.

   Be sure to check your In Basket for results and messages from your administration staff or other clinicians.

Also, remember to check for My Open Encounters in the In Basket, review the messages and close the encounter when all documentation has been completed.

Note: Other workflows exist. The previous examples are the most common and straightforward workflows within ***e*CLINICIAN - EMR**.

2. **I have My Open Encounters and My Open Charts folders. What is the difference?**

   My Open Encounters refers to unscheduled visits (i.e. Telephone Call, Refill Medication and Orders Only encounters). The My Open Encounter message(s) show up in In Basket of the user that opened the unscheduled encounter immediately after opening the encounter.

   My Open Charts refers to scheduled visits and shows up in the In Basket of the scheduled provider one day after opening the chart if the chart is not closed.

3. **Why is there a Letter Queue folder in my In Basket?**

   A physician or other provider has routed a letter to you for processing.

4. **How do I process a letter in my In Basket Letter Queue folder?**

   Use the **Comm Mgt** button to edit the letter. If the letter is final, send the letter. The Letter Queue message will automatically disappear.

   If you want to save edits and send the letter to another user for review, **Pend** the letter and **Forward** the Letter Queue message to the reviewer.

LABS

1. **How do I communicate lab results with my patient's Primary Care Provider (PCP)?**

   You can copy the PCP, or any other provider, when ordering your lab. To do this:

   - Order the lab in the Meds & Orders section.
   - Click on the blue hyperlink to open the lab details.
   - Complete the Questions section with the name and location of the provider for whom you would like to CC the lab results.
   - The lab will manually enter this CC information into their system and the lab results will be sent via hardcopy and/or to the CC provider's In Basket results folder.

2. **What Lab requisitions printed from *e*CLINICIAN are not accepted?**

   See Printing: 1d. ***e*CLINICIAN** requisitions not accepted.

3. **I now get duplicate lab results in the *e*CLINICIAN In Basket Results folder as well as hardcopy paper results. How do I stop the hardcopy paper results?**

   Contact your Subject Matter Expert (SME) on how to make this happen.

4. **I can't find the Lab I need in *e*CLINICIAN. What do I do?**

Document that you've ordered this lab in the progress note.

Complete a paper requisition for the patient.

Contact the ***e*CLINICIAN** team.

RESULTS

1. **I can't find my results in *e*CLINICIAN. Why?**

   ***e*CLINICIAN - EMR** is a shared information tool where some data elements are shared in a similar fashion to Alberta Netcare. Privacy and security rules determine access to other data elements. The two tables below list:

   A. Clinical data found in ***e*CLINICIAN - EMR**. To view patient data prior to the listed dates, you must use Alberta Netcare or paper sources.

   B. Clinical data ***NOT*** found in ***e*CLINICIAN – EMR**. To review results from sources not listed, you must to use Alberta Netcare or paper sources.

Importance of Checking Netcare for Results

At this time, some results do not come into ***e*CLINICIAN**. It is important to check Netcare if you are expecting results and they are not appearing in ***e*CLINICIAN**.

Table A

Data Source	Date Available	Results Back To	Name of Chart Review Activity Tab
Lab Data			
AHS facilities			
• Edmonton area (All Facilities)	15 Apr 08	01 Jan 06	Lab
• North zone (Northern Lights)	15 Apr 08	01 Jan 06	Lab
Provincial			
• Provincial Lab (Edmonton zone)	01 May 08	01 May 08	Lab
• Provincial Lab (Province Wide)	19 July 12	19 July 12	Lab
• Newborn Metabolic Screening	01 June 08	01 June 06	Lab
Cross Cancer Institute	28 Jun 10	28 Jun 10	Lab
DynaLIFE (formerly DKML) collection sites Edmonton and area Central: Red Deer, Lloydminster, & Smith Clinic Camrose (where tests are performed at Dynalife Edmonton Main Lab)	15 Apr 08	01 Jan 06	Lab
Electrodiagnostics (ECG)			

Data Source	Date Available	Results Back To	Name of Chart Review Activity Tab
All AHS Edmonton and area facilities • ECG PDFs	15 Apr 08	Feb 07	Lab
Transcribed Reports			
All AHS Edmonton facilities • Operative Report • Progress Report/Clinic Report • Discharge Summary • Home Care Summary • Consultation • History • Letter • Neurophysiology (EEGs) • Cardio diagnostic • Emergency Dept Reports (scanned)	15 Apr 08	01 Jan 06	Notes
Diagnostic Imaging Text Reports			
All AHS Edmonton facilities (Text)	15 Apr 08	01 Jan 06	Imaging
Medical Imaging Consultants (MIC) – Edmonton zone (PDF)	15 Apr 08	15 Apr 08	Imaging
Insight Medical Imaging (IMI) – Edmonton zone (Text)	15 Apr 08	15 Apr 08	Imaging
CML Healthcare – Edmonton zone (PDF)	15 Oct 08	15 Oct 08	Imaging
Endoworks Reports			
RAH and UAH sites Procedure Notes – "Colorectal Cancer Screening – CRC" exam procedure report	04 April 13	01 Jan 06	Procedures

Table B

The ***e*CLINICIAN - EMR** patient chart ***DOES NOT*** contain clinical data from the sources listed in the table below:

Lab Results
• AHS -Calgary (All Facilities) • AHS - Cancer Tom Baker Centre Calgary • AHS - Central (All Facilities) • AHS - South (All Facilities) • Canadian Blood Services • HLA Lab Results
Diagnostic Imaging
• Amiha Diagnostic Imaging (St. Albert) • Breast Centre Radiology • Canada Diagnostic Centres (CDC) – Westgate X-Ray and Ultrasound • Cross Cancer Institute • Devon X-Ray Clinic • Dr. J.P. Mayo • Edmonton Cardiology Consultants at UAH and RAH - Echocardiograms • Glenwood Radiology • Pureform Diagnostic Imaging Clinic – includes Echocardiography (Sherwood Park) • The X-Ray Clinic at Northgate Centre • The X-Ray Clinic at 124th Street • The X-Ray Clinic at 142nd Street DI results from ALL facilities outside Edmonton and area are ***NOT*** found in ***e*CLINICIAN**.
Electrodiagnostics
• PDF Files: o Heart Diagram o MAHI Stress and Holter Tests o Paceart
Other Results
• AHS Edmonton - Tuberculin Skin Tests • Immunizations Community Clinic

LETTERS / REFERRAL LETTERS

1. **What letter template should be utilized for windowed envelopes?**

   Utilize the "blank letter 0.75" letter template in order for the letter to be processed with a windowed envelope.

2. **How do I write a letter to a Provider Office, a Group of Providers, or a Community Program?**

   For these letters, utilize the **Other** button in the Communications section to manually enter the name of the group being addressed. This window contains fields for adding the fax number and address as appropriate.

3. **I've addressed a letter to my provider(s). How do I pull these names into my letter?**

   SmartPhrase for pulling in the name of the first provider in the provider letter list:

   - .cclistfirst - pulls in full name and address
   - .cclistfirstLname - pulls in only the last name
   - cclistrest - pulls in the name(s) of the remaining provider(s) in the provider letter list

4. **Why does the Referring Provider not display or populate when I am creating a consult letter?**

   In order to pull the Referring Provider into letters or any of the clinical follow-up tools, the referring provider must be populated during patient registration.

5. **I can't find the referral letter for this patient. Where is it?**

   All referrals are scanned or imported into ***e*CLINICIAN** and can be found in the Chart Review activity, Media tab. You can filter these documents by document type = referral to find all referrals for the patient.

6. **I started my letter but have changed my mind and I don't want to keep it. What do I do?**

   You may choose to ***pend*** your letter so you can edit it and continue later. To do this, click the **Pend** button on the bottom right of the section. (**Note:** the encounter cannot be closed until all letters are marked as sent or routed to someone for follow-up).

   You may choose to cancel your letter. To do this, click the **Cancel** button on the bottom right of the section.

Medication Documentation / Meds and ORDERS

1. **How do I add comments while documenting patient reported medications in the Medication Documentation section?**

   - To add comments for an individual medication, next to *Instructions*, select **Click to Add Text.** Enter the comments in the Instructions field.
   - To add a comment regarding the entire medication list, at the top of the Medication Documentation window, click **Add Note.**

2. **The medication I want to add is not available on the list. What do I do?**

   If you're in the Medication Documentation section:

   - Add Other Medication or Other Vitamin and enter a comment in Instructions identifying the name of the medication/vitamin. Select **Click to Add Text.**
   - For Insulin – do not change the dose in the dose field; rather document the dose change in *Instructions*. Select **Click to Add Text.**

   If you're in the Meds & Orders section:

   - Be sure to check the Database Lookup Tab (F7) for a larger selection of medications to choose from.
   - Use fewer letters when searching i.e. Rather than entering Tylenol, enter the first three letters: Tyl
   - If you still can't find what you're looking for then order Other Medication and document the name of the medication in the Medication Name field of the questionnaire.

   Note: If this is a **Patient Reported** medication you must change **Class** to **Historical Med** so no prescription is printed and the medication is clearly identified as patient reported.

   Note: Medications entered as Other are reviewed quarterly and those medications re-occurring most often are added to the discrete list of medications in the system.

3. **Why do I have duplicate orders?**

   An order was previously placed in the last 14 days for the same item that you ordered. If the new order is still applicable, continue with signing of order.

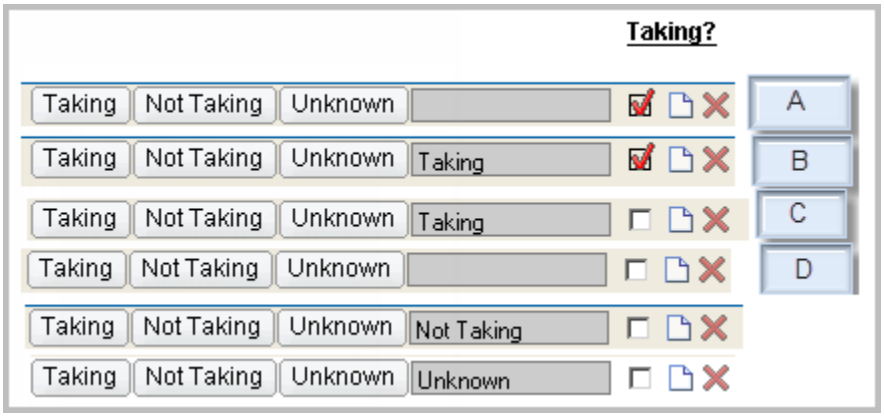
4. **How do I re-print my prescription?**

   Go to the Order Entry Activity, open Previously Signed Orders, and click the **Reprint** button. **Note:** You can only reprint to the same printer as originally used. If you need to print at a different printer you will need to cancel the prescription and re-order it from the workstation mapped to the desired printer.

5. **What is the quickest way to view the orders placed in an encounter?**

Use the Rooming Report available from the Multi Provider Schedule.

6. **What are all the boxes and checkmarks in the Med Documentation section?**



Medications in this section are intended to be reviewed in each encounter and documented by clicking the **Taking, Not Taking** or **Unknown** buttons.

If medications have been abstracted and no medications have been reviewed (i.e. no one clicked the **Taking, Not Taking** or **Unknown** buttons in a previous encounter) then you would see Row D above, for each medication abstracted, when you open your first encounter following an abstract encounter.

When you enter a new medication in this section, the ☑ is populated in the Taking? checkbox automatically. However, the grey box is left blank (Row A above). The grey box is populated only after clicking one of the **Taking, Not Taking** or **Unknown** buttons (Row B above). It is intended that one of these buttons will be clicked as each medication is reviewed with the patient in each encounter.

The ☑ is cleared with the start of each new encounter to indicate that the medication has not yet been reviewed in the current encounter. Therefore, you would typically see Row C above, following an encounter where these medications had previously been reviewed, but not yet in this encounter.

When you click the **Not Taking** or **Unknown** buttons the ☑ is cleared from the *Taking?* checkbox.

Medical History

1. **How do I document Pertinent Negatives?**

   AHS directive > pertinent negatives should be documented in the Progress Notes.

MPS (Multi Provider Schedule) / Joint Appointment

1. **How do I clearly identify that my patient is in a joint appointment with another provider?**

   Add the Enc Provider and Joint columns to the MPS (Multi Provider Schedule).

2. **How do I add a column to the MPS (Multiple Provider Schedule)?**

   - While viewing the MPS, find My Schedule on the left hand side of your screen.
   - Highlight your name (your schedule) and right-click to select Properties.
   - You will be on the General tab.
   - Scroll down Available Columns on your left until you find the columns you want to add.
   - Highlight the column and click the **Add** button which is in the middle of your screen between Available Columns and Selected Columns.
   - Click **Accept** and return to the MPS.

Netcare

1. **How do I see transcribed reports that have been CC'd to me from Netcare?**

   These reports show up in the CC'd Charts messages folder in your In Basket.

2. **How do I see letters dictated in Netcare?**

   Letters dictated into Netcare are automatically posted to ***e*CLINICIAN** Chart Review > Notes Tab.

Passwords

1. **My password isn't working. Can you reset it?**

   The ***e*CLINICIAN** team cannot reset passwords. For ALL password issues (AHS Login Accounts, AD Accounts, NT Login, Netcare Login, ***e*CLINICIAN** Login) for ALL staff (physicians or AHS staff), call the Help Desk at 780-735-4357 (HELP).

PREFERENCE LISTS

1. **How do I copy a preference list?**

   In the Preference List Composer (Epic button > Tools > Preference List Composer), click on the **Copy User** button on the bottom left-hand corner of the screen.

PRE-WORK

1. **I want to prepare my EMR chart prior to my scheduled visit. How do I do that?**

   RN's and Clerks should do pre-work in an Orders Only encounter. They should ***not*** perform pre-work on a physician's scheduled visit.

   MDs can perform pre-work on their own scheduled visits. However, if the patient is a no show, the MD must address the open encounter by entering a Visit Diagnosis and Progress Note to close the encounter. If the Visit Diagnosis is unknown, use the Erroneous Encounter – Disregard (code 10000). For the Progress Note, you can type ***Patient did not show*** or ***Encounter opened in Error***.

PRINTING: LAB REQUISITIONS / PATIENT INSTRUCTIONS / PROGRESS NOTES / SICK NOTE

1. **My Lab requisition isn't printing. Why?**

   Lab requisitions will not print if Status = Normal.

   - Orders which require the completion of a paper form or will be assigned to another provider in the clinic, have a status of Normal. To print, an order must have a Status of Future or Standing.
   - Ensure you have placed the correct order.
   - If necessary change the status.
   - Sign the order.

   Labs are printed ***after*** signing the order.

   If you've already signed the Lab order and it did not print you have two options:

   - You can give a hardcopy lab requisition to the patient
   - You can cancel the Lab order you just signed in ***e*CLINICIAN** and order the Lab again using Status = Future or Standing

   Note: *e*CLINICIAN requisitions NOT accepted include:

   - All requisitions to the Mazankowski (i.e. Angiogram, Cardiac Ultrasound, ECHO, Stress Test, 24 Holter Monitor).
   - Blood Bank

- Bone Marrow Aspiration
- Bronchoscopy
- ECG (not accepted at AHS or Mazankowski)
- EEG orders – this is an internal referral to Neurology
- EMG
- Lithotripsy
- Nuclear Medicine (i.e. NB Stress MIBI – Nuclear Medicine Cardiac Stress Test)
- PFT
- Referrals

The provider should still ***order*** these requisitions in ***e*CLINICIAN** with Class = No Print, so we have an electronic record of these tests, in addition to completing the paper forms used before.

EEG orders are an internal referral to Neurology and the paper referral form process must be followed.

2. **How do I print multiple requisitions for the same test?**

   Place the requisition Order in ***e*CLINICIAN**, sign and print, then select the **Epic** button > Tools > Printer Status and print additional copies. Do not photocopy the requisition.

3. **My phone number isn't printing on the requisition. Why not?**

   The department phone and fax numbers are printed on Prescriptions and Lab requisitions, not individual user information.

   Physician information (primary provider's phone & fax numbers) are printed on DI requisitions only.

4. **How do I print patient instructions?**

   - From the Visit Navigator toolbar, click Print AVS.
   - While in the visit navigator – select down arrow beside printer icon on Hyperspace toolbar (very top right hand corner), select Print Patient Instructions.
   - If you do not have an open encounter, go to Chart Review activity, Notes tab, check the Pt Instr checkbox, click the printer icon (bottom half of screen, upper left hand side).

5. **How do I print progress notes?**

   - From the MPS (Multiple Provider Schedule) : select patient visit in schedule with single click, window will open up on bottom half of screen for patient reports, select the Rooming Report, right-click inside report itself and select Print.

- If you do not have an open encounter, go to Chart Review activity, Notes tab, deselect the Pt Instr checkbox, click printer icon (bottom half of screen, upper left hand side).

6. **How do I print a Sick Note?**

- From within the encounter, go to Communications, In recipients, select Patient. From the other Templates, To Whom It May Concern Letter, enter info and print.

PRINTING ISSUES

A simple way to alleviate any Windows printing issues (i.e. Netcare) is to restart the PC.

Some print jobs (PDF) are getting hung up in the print queue and users are unable to print from ***e*CLINICIAN**.

When reporting printing issues you must supply the Room #, User, Computer ID, Citrix server & Printer ID and Order ID if you are having issues printing an order.

To obtain the Computer ID (also called the Workstation ID) go to My Computer > Properties OR **Epic** button > Help > About Hyperspace. The name stickers on the monitors are not accurate computer IDs.

If the issue is with printing an order, in the Meds & Orders section, click on the Order to expand, then click Report. Click on Order Details, the order information at the bottom will tell you the Order ID, which workstation it was ordered from, and Destination Workstation (Printer) it was printed on.

If this is an immediate need for Windows Printing only, to add a printer from ***e*CLINICIAN,** follow these instructions:

- From the Start menu at the bottom left corner of screen, select settings.
- Select Printers & Faxes.
- Select Add Printer (double click).
- From the Printer Wizard, select Next.
- Select Network Printer.
- Select Next.
- Select Connect to this printer.
- Select Next.
- Type in your printer server.
- From the dropdown list, select the appropriate printer for the exam room. Note that printer numbers are assigned by exam room number in the specific clinic area.

PROGRESS NOTES

1. **I want to pull my progress note into my letter. How do I do that?**

   Use the SmartLink .pnotes to pull in the entire progress note into your letter.

2. **I only want to pull a portion of my progress note into my letter. Can I do that?**

   Yes. In your progress note use the two SmartLinks: .letterbegin and .letterend to identify the block you want to include in your letter. When you are in your letter use the SmartLink .lettertext to pull this block into your letter.

SCANNING / IMPORTING / HARDCOPY DOCUMENTATION

1. **My patient brought in his care log from home (Example: Food logs, glucose tests, BP readings). What do I do with that?**

   Hardcopy documentation can be scanned into the patient's encounter as a specific document type. Please see your Subject Matter Expert (SME) regarding what document type to use for various documents.

   Valid file types for Importing are: .jpg, .png, .tif, .tiff, .pdf

2. **I scanned a document into *e*CLINICIAN and now I can't find it. Where is it?**

   All scanned documents are in Chart Review under the Media tab. You can filter on Document Type to select only those types of documents you're looking for.

3. **Scanning isn't working for me. Why?**

   See Systems Issues for details.

SYSTEM ISSUES

1. **I keep getting kicked out of *e*CLINICIAN. What can I do?**

   When exiting ***e*CLINICIAN** and Citrix, be sure to ***Log Out*** of ***e*CLINICIAN** and Log Off of Citrix rather than using the X in the upper right hand corner of your screen. This will avoid a number of multiple server session related issues. If you've done this and still encounter problems, please call the Help Desk (780-735-4357).

2. **Scanning isn't working for me. Why?**

   When you log in to Citrix for the first time you will get a Client Scanner Security pop up window with Question 1: Do you want to grant access? Select *Yes, Full Access*. Question 2: Do you want to be asked again? Select *Never ask me again*. This will allow scanning functionality and you will not get the pop up again.

   If you don't get this pop up window, then select the Program Neighbourhood Connection Center (red ball icon on your desktop lower right corner) to open the popup window and answer the same questions appropriately.

If you keep getting this popup window, then Select *Never ask me again*.

3. **My computer still doesn't want to work. I need help. What should I do?**

   For any technical issues with ***e*CLINICIAN**, please gather the following details to give to the Help Desk (780-735-4357) when you call:

   - User's name (person logged into ***e*CLINICIAN**)
   - Citrix server name
   - Computer name
   - Patient name, ULI (see ULI section)
   - The encounter you were working in and what you were doing in that encounter when you ran into problems, i.e. type and date of encounter (telephone encounter, orders only encounter, visit encounter), task (letters, progress notes, history).

TELEPHONE ENCOUNTER / MOA ROLE

1. **The Doc Flowsheet SmartLink isn't working in my telephone encounter documentation section. What do I do?**

   Smart Links for Flowsheets do not work in a Telephone Encounter. If you need to use the Flowsheet Smart Links then use the Orders Only encounter.

2. **Can I drop a physician billing code for a telephone encounter?**

   Yes. See Billing Codes / Fee for Service / ESL (Electronic Service Log).

3. **I have the MOA role and receive a patient message. Do I open a telephone encounter?**

   Two methods exist depending on the situation:

   - To document directly on the patient's chart, create a telephone encounter and route to the appropriate individuals.
   - To request guidance prior to any documentation on a patient's chart, send an In Basket Call Back message to the appropriate individuals.

ULI

1. **How do I find the ULI for my patient?**

   The ULI displays in the Patient Workspace Header.

VISIT DIAGNOSIS / REASON FOR VISIT / CHIEF COMPLAINT

1. **I can't find the Visit Diagnosis I want. What do I do?**
    - Once you're in the search screen, click **Database Lookup (F5)** button in the lower left hand corner of your screen for a larger selection of diagnoses to choose from.
    - Enter fewer letters to widen your search (e.g. enter 'pulm' rather than 'pulmonary')
    - If you still don't find what you need please contact your Subject Matter Expert (SME) for advice on how to proceed.

    Note: If you find yourself using the same diagnosis frequently, add it to your preference list by right-clicking on the diagnosis and select Add to Common Dx Preference List.
2. **I can't find the Reason for Visit / Chief Complaint I want. What do I do?**
    - Once you're in the search screen, press the **Database Lookup (F5)** button in the lower left hand corner of your screen for a larger selection to choose from.
    - Enter fewer letters to widen your search (e.g. enter pain rather than back pain)
    - If you still don't find what you need, you can select Other and indicate the details in the comment field.
    - Also, please contact your Subject Matter Expert (SME) for advice on how to request that your reason for visit be added to the list.

    Note: If you find yourself using the same reason for visit frequently, add it to your speed buttons by right-clicking on the reason for visit and selecting **Add to Speed Buttons**.

WORKFLOWS

CHECKOUT WORKFLOW

1. **Orders are being missed. How do I ensure all orders placed during the visit are caught?**

    When checking out the patients, the front desk should put in a process for all patients who have had orders placed during that visit.

LETTER WORKFLOW

1. **How do the physician and his/her administration staff coordinate completion of letters using In Basket?**

The physician edits letters via the **Comm Mgt** button in his/her Letter Queue folder toolbar. S/he pends the letter. In the In Basket, s/he uses the **Forward** button to notify the administration staff that the letter is ready for final prep.

Administrative staff use the **Comm Mgt** button in his/her Letter Queue folder toolbar to make final edits, review and Send (i.e. print) the letter. Once sent, the Letter Queue message automatically disappears.

2. **How do I ensure accurate provider addresses for my letters?**

This requires coordination between the administration staff and physicians at the time of scheduling the appointment, check-in and creating the provider letter.

At the time of scheduling the appointment:

- The referring provider is selected from the list in the system. If this has been done correctly, the referring provider's name and address can be pulled into the letter.
- If the referring provider is not found in ***e*CLINICIAN**, administrative staff should send a Provider Record Request message to request the provider be added to the system.
- Once the referring provider is available in the system, the front desk staff would update the appointment prior to or at check-in.

PCP name and address is not required when scheduling an appointment. Administrative staff must use the Care Team activity to add this information in order for it to be pulled into the letter.

At the time of Check In, front desk staff has the option to add or verify the PCP:

- Click on the PCP stethoscope icon.
- If the PCP exists, click on the Green Street icon to select the correct address.
- If the PCP is missing, add the PCP and select the correct address.

At the time of creating the provider letter, click the Referring Provider and/or PCP buttons and the correct information will pull into the letter.

REFERRAL WORKFLOW

1. **How do I order an outgoing referral?**

Order a referral in the Meds & Orders section to document the referral in the system.

- Complete your paper process as you would have done prior to using ***e*CLINICIAN** because the *e*-Referral system is not live yet.
- If the physician you're referring the patient to is live on ***e*CLINICIAN** you still must follow this same paper process.

APPENDIX B: SYSTEM SMARTPHRASE EXAMPLES & NAMING CONVENTIONS

System SmartPhrases cover many topics, including common words, medical terms, and phrases to document review of systems, physical exam, and complete visits.

REVIEW OF SYSTEMS SMARTPHRASES

- For reviews of systems in which patients report positive symptoms, SmartPhrases begin with ***.pos***.
- For reviews of systems in which patients report negative symptoms, SmartPhrases begin with ***.neg***.

Examples include:

SmartPhrase	Description
.posdm	Positive review of systems – diabetes mellitus
.posgerd	Positive review of systems – gastroesophageal reflux disease
.negdm	Negative review of systems – diabetes mellitus
.neglbp	Negative review of systems – lower back pain

PHYSICAL EXAM SMARTPHRASES

- Phrases for exams with positive findings will begin with ***.pex***.
- Phrases for exams with negative findings will begin with ***.nex***.

Examples include:

SmartPhrase	Description
.pexabd	Positive findings – abdominal exam
.pexdm	Positive findings – diabetes mellitus
.pexgen	Positive findings – general exam
.pexlbp	Positive findings – lower back pain
.nexabd	Negative findings – abdominal exam
.nexdm	Negative findings – diabetes mellitus
.nexlbp	Negative findings – lower back pain
.nexthy	Negative findings – thyroid

COMPLETE VISIT SMARTPHRASES

All of the complete visit SmartPhrases begin with ***.cv***.

SmartPhrase	Description
.cvbronchitis	Complete Visit – bronchitis
.cvdm	Complete Visit – diabetes mellitus
.cvgerd	Complete Visit – gastroesophageal reflux disease
.cvlbp	Complete Visit – lower back pain
.cvwellchild	Complete Visit – well child
.cvww	Complete Visit – well woman

OTHER SMARTPHRASES

The following other SmartPhrase naming conventions may also assist you in finding system SmartPhrases in ***e*CLINICIAN**.

SmartPhrase	Description
.also	Additional complaints. Examples include: .alsofatigue
.drug	Medication information. Examples include: .druginsulin and .drugfosamax
.in	Instructions for the patient. Examples include: .inchol and .insmoking
.prob	Problem-specific notes. Examples include: .probdiabetes and .probcopd
.proc	Procedure notes. Examples include: .procflexsig and .procskintag

APPENDIX C: USEFUL SMARTLINKS

Following is a list of SmartLinks that can be especially useful while charting. Keep in mind that this isn't a complete list. However, it provides a starting point for the types of SmartLinks that are available.

Area	SmartLink	Format	Description
Allergy	**.alg**	Prose	Summary of patient's allergies
	.algenc	Table	Allergies as of the current encounter
	.algp	Prose	Patient's allergies
	.allergy	Table	Patient's allergies presented
Demographics / Patient	**.fname**	Prose	Patient's first name
	.lname	Prose	Patient's last name
	.name	Prose	Patient's full name
	.age	Prose	Patient's age as of today
	.sex	Prose	Patient's sex
	.add	Prose	Patient's address (all lines)
	.dob	Prose	Patient's date of birth
	.hmph	Prose	Patient's home phone number
	.ph	Prose	Patient's phone numbers
	.mob	Table	Patient's mobile/cell phone number
	.wkph	Prose	Patient's work phone number
	.pcp	Prose	Patient's primary care provider
	.mrn	Prose	Patient's medical record number
	.his	Prose	His or her in lower case
	.caphis	Prose	His or her in upper case
	.he	Prose	He or she in lower case
	.caphe	Prose	He or she in upper case
	.him	Prose	Him or her
	.me	Prose	User's name
User-Related	**.logindept**	Prose	Adds your login department to documentation
Vitals	**.bsa**	Prose	Patient's body surface area
	.lastbp	Table	Most recent blood pressure reading*
	.lasthc	Table	Most recent head circumference measurement*
	.lastht	Table	Most recent height reading*
	.lastpulse	Table	Most recent pulse reading*

Area	SmartLink	Format	Description
	.lastresp	Table	Most recent respiration reading*
	.lasttemp	Table	Most recent temperature reading*
	.lastwt	Table	Most recent weight measurement*
	.multiplevitals .mvitals .vitalsmultiple .vitalsm	Table	Displays flowsheet data for a patient in tabular format and includes a row for each item of data that was recorded in the flowsheet. If the Multiple Vitals navigator section is not enabled, this SmartLink displays existing vitals stored in the patient record.
	.v	Prose	Visit vital signs on one line
	.vs	Prose	Visit vital signs separated by slash lines
	The asterisk * indicates that the number of readings to display is a parameter in the SmartLink. To use the SmartLink, enter the SmartLink (.lastbp, for example) followed by the number of readings you want to display. Enclose the number of readings in square brackets. Example: .lastbp[2] In this example, the SmartLink displays the two most recent blood pressure readings on record for the patient. By default, these SmartLinks look back from today's date to search for the vitals.		
Visit Info	.cc	Table	Chief complaint
	.rfv	Table	Reason for visit
	.pnotes	Prose	Visit progress notes
History	.alchx	Table	Patient's alcohol history
	.alchxp	Prose	Patient's alcohol history
	.drughx	Table	Patient's drug history
	.drughxp	Prose	Patient's drug history
	.famhx	Table	Patient's family history
	.famhxp	Prose	Patient's family history
	.hxped .ped	Prose	Patient's pediatric history. Displays such information as birth weight, birth length, head circumference, discharge weight, and delivery method.
	.hxpmh .medicalhx .pmh	Table	Past medical history
	.hxpsh .psh .surgicalhx	Table	Past surgical history

Area	SmartLink	Format	Description
	.ob	Table	Status of the pregnancy history (not asked, never pregnant, or history of pregnancy) and the information from the pregnancy history fields
	.obhist	Table	The same information as .ob is displayed, along with the information entered in the Pregnancy Outcome table
	.prob	Table	Problem list with no comments listed
	.probl	Table	Extended problem list including comments
	.pshp	Prose	Patient's past surgical history
	.sacthx	Table	Patient's sexual activity history
	.sexhxp	Prose	Patient's sexual activity history
	.soc	Table	Social history, including activities of daily living info and any text in the Social Documentation field
	.tobhx	Table	Patient's tobacco history
	.tobhxp	Prose	Patient's tobacco history
	.ed	Prose	Date of the current encounter
	.fdate	Prose	Formal date
	.smokeces	Prose	Pulls tobacco cessation information into progress notes
Date/Time	.now	Prose	Current time
	.td	Prose	Today's date
	.afutappt	Table	Displays all future appointments. If no appointments exist, the text "No future appointments." displays.
Diagnoses	.diag	Table	Encounter diagnoses, along with the orders associated with each diagnosis
	.diagx	Table	Abbreviated encounter diagnoses
Medications	.cmed	Table	A list of the patient's current medications
	.cmeds	Prose	Patient's current medications displayed on a single line
	.dcmed	Table	Medications discontinued in this encounter
	.cmedp	Prose	Displays medications in generic name format and is configurable as noted in the smart links below.
	.cmedp[1	Prose	Displays medications in generic short name and brand short name format
	.cmedp[1,1	Prose	Displays medications in generic and brand short name formats and displays the patient's sig
	.cmedp[,1	Prose	Displays medications in generic name format and displays the patient's sig

Area	SmartLink	Format	Description
	.cmedp[,,1	Prose	Displays medications in generic and brand short name formats and displays medication dose and form
	.cmedp[,1,1	Prose	Displays medications in generic and brand short name formats with patient's sig
	.encmed	Table	Encounter medication list
	.encmedp	Prose	Patient's encounter medications
	.med	Table	All current medications that were ordered before the current encounter
	.medscurrent	Prose	Current medications
	.ltmed	Table	Long-term medications
	.refill	Prose	Requested medications
Results	**.getlabs**	Table	Lab results from previous visits and the current encounter. Use .getlabs to display all of the lab results information in one SmartLink. Example: GETLABS[6M,1 The "6M" instructs ***e*CLINICIAN** to search 6 months back from the day of the visit the user is presently in to find and display all lab component values in that time period. Entry for this parameter may be in the form #D, #W, #M, or #Y. The "#" indicates a number and the D, W, M, Y stand for days, weeks, months, or years respectively. If no entry is specified for this parameter (.GETLABS[,1), or if there are no results that fall within the time period indicated, then ***e*CLINICIAN** displays the last known result. The second parameter controls the display of the SmartLink. It accepts a blank entry, "1", or "2". A blank entry displays the component name, value, high and low ranges, status and any comments. An entry of "1" displays everything stated above except for the comments. An entry of "2" displays an abbreviated name and value for each component.

Area	SmartLink	Format	Description
	.brieflab or .labbrief	Table	Component name, lab result, and date resulted for most recent labs. This is an abbreviated version of the lastlab SmartLink. The SmartLink accepts a list of result component base names separated by commas. The user can also request the number of results to display for each component. To indicate the number of results for each component, type the component name followed by a colon and then the number of results. For all results for that particular component, type an asterisk in place of the number. To obtain the last result for a particular component, type the component base name without the colon, number, or asterisk. Example: .brieflab[MCH:3,MCV:*,HCT This example would display a table for all components whose base name matches MCH, MCV, or HCT. The first would contain the last three results of each component that has a base name of MCH, the second would contain all the entered results for components with MCV as the base name, and the third would contain the last entered result for all components with a base name of HCT.
	.lastlabv .lablastv	Table	Lab results for previous visits in table format. It accepts two parameters separated by commas, which specify the duration and the format of the output. Example: .lastlabv[6M,1 The "6M" indicates to search six months back from the day of your open encounter to find and display all lab component values in that time period. Entry for this parameter may be in the form #D, #W, #M, or #Y. The "#" indicates a number and the D, W, M, Y stand for days, weeks, months, or years respectively. If no entry is specified for this parameter (.lastlabv[,1), or if there are no results that fall within the time period indicated, then the last known result displays.

Area	SmartLink	Format	Description
	.lastlab **.lablast**	Table	Most recent information on the requested components, including a table listing the date, result value, low and high reference range, and the result status for each result requested. The SmartLink accepts a list of result component base names separated by commas. The user can also request the number of results to display for each component. To indicate the number of results for each component, type the component name followed by a colon and then the number of results. For all results for that particular component, type an asterisk in place of the number. To obtain the last result for a particular component, type the component base name without the colon, number, or asterisk. Example: .lastlab[MCH:3,MCV:*,HCT This example would display tables for all components whose base name matches MCH, MCV, or HCT. The first would contain the last three results of each component that has a base name of MCH, the second would contain all the entered results for components with MCV as the base name, and the third would contain the last entered result for all components with a base name of HCT.
My Sticky Note	**.mysticky**	Prose	Pulls information from My Sticky Note into a Progress Note.
Communication Management	**.fromaddr**	Prose	Displays the From address.
	.ltrfrom	Prose	Displays the name of the letter author in the text of a letter.
Follow Up	**.followup**	Prose	Pulls follow-up instructions into desired documentation.

APPENDIX D: COMPARISON OF MEDICATION-RELATED SMARTLINKS

Name	Format	Displays…	Includes Patient Reported (PR) Meds?	Reflects Meds Discontinued this encounter?	Example / Notes
.med	table	current med list **before** the start of the current encounter ***see caution**	yes	yes	Caution: Consider using the **encmedstart** SmartLink instead as this SmartLink updates to also reflect changes made to the medications during the current encounter.
.cmed	table	all current meds	yes	no	
.cmeds	prose	all current meds	yes	no	"Current outpatient prescriptions:atorvastatin (LIPITOR) 10 mg Oral tablet, take 1 Tab (10 mg total) by mouth daily, Disp: 90 Tab, Rfl: 5"
.cmedp	prose	all current meds	yes	no	"has a current medication list which includes the following prescription(s): atorvastin"
.cmedpwithsig	prose	all current meds	yes	no	"has a current medication list which includes the following prescription(s): atorvastatin - take 1 Tab (10 mg total) by mouth daily"
.cmedp[1	prose	all current meds	yes	no	"has a current medication list which includes the following prescription(s): atorvastatin (LIPITOR)"
.cmedp[1,1	prose	all current meds	yes	no	"has a current medication list which includes the following prescription(s): atorvastatin (LIPITOR) - take 1 Tab (10 mg total) by mouth daily"
.cmedp[,1	prose	all current meds	yes	no	"has a current medication list which includes the following prescription(s): atorvastatin - take 1 Tab (10 mg total) by mouth daily"
.cmedp[,,1	prose	all current meds	yes	no	"has a current medication list which includes the following prescription(s): atorvastatin (LIPITOR) 10 mg Oral tablet"

Name	Format	Displays…	Includes Patient Reported (PR) Meds?	Reflects Meds Discontinued this encounter?	Example / Notes
.cmedp[,1,1	prose	all current meds	yes	no	"has a current medication list which includes the following prescription(s): atorvastatin (LIPITOR) 10 mg Oral tablet - take 1 Tab (10 mg total) by mouth daily"
.cmedsigonly	table	all current meds	yes	no	Dispense and Refill columns are missing from the table
.dcmed	table	only meds **discontinued** during current encounter	yes	yes	
.encmed	table	all current meds	yes	yes	Displays the same medications as the **.cmed** SmartLink but it also lists any medications discontinued during the current encounter
.encmedp	prose	all current meds	yes	yes	"I have discontinued Mr. M's bisoprolol - take 1 Tab (10 mg total) by mouth daily. I am also having him maintain his amlodipine - take 1 Tab (10 mg) by mouth daily"
.encmedstart	table	current med list ***before*** the start of the current encounter	yes	no	This SmartLink **does not** reflect medication changes for the current encounter.
.encmedsexclpr	table	meds ordered during ***current*** encounter	no	no	
.ltmed	table	only the current medications flagged as **long term**	yes	no	
.ltmedp	prose	only current	yes	no	"has a current medication list which includes the following

Name	Format	Displays…	Includes Patient Reported (PR) Meds?	Reflects Meds Discontinued this encounter?	Example / Notes
		medications flagged as **long term**			long-term medication(s): ramipril, levothyroxine, and hydrochlorothiazide."
.medadmin	table	only meds administered in current encounter	no	no	
.medadminprose	prose	only meds administered in current encounter	no	no	
.avsmedlist	table	all current meds	yes	yes	Provides a cleaner table of patient's current medications intended for patient after visit summary. Additional brand or generic name and patient sig displays.
.avscmedlist	table	all current meds	yes	no	Provides a cleaner table of patient's current medications intended for patient after visit summary. Additional brand or generic name and patient sig displays.
.avscmedlistclinicalsig	table	all current meds	yes	no	Provides a cleaner table of patient's current medications with a clinical sig intended for letters to clinicians. Additional brand or generic name and patient sig displays.
.actmed	table	only the current medications marked as Taking	yes	no	

Additional Notes:

- There is not a SmartLink that just displays Patient Reported (PR) medications.
- There is not a version of the **.med** SmartLink that displays in Prose format.

SCREENSHOT EXAMPLES

SCREENSHOT 1

To see the patient current medication list prior to the start of the current encounter, use **encmedstart**.

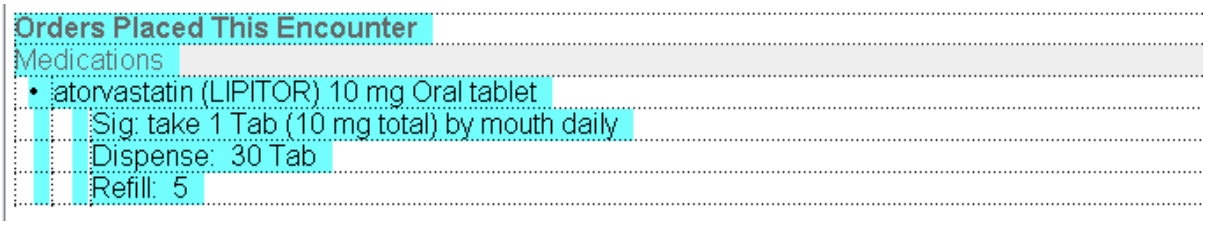
Outpatient Prescriptions Prior to Visit

Medication	Sig	Dispense	Refill
• ramipril (ALTACE) 5 mg Oral capsule	take 1 Cap (5 mg total) by mouth daily	90 Cap	7
• omeprazole (LOSEC) 20 mg Oral tablet	take 1 Tab (20 mg total) by mouth daily	90 Tab	7
• levothyroxine (SYNTHROID) 75 mcg Oral tablet	take 1 Tab (75 mcg total) by mouth daily	90 Tab	7
• hydrochlorothiazide (HYDRODIURIL) 25 mg Oral tablet	take 1 Tab (25 mg total) by mouth daily	90 Tab	7

No facility-administered medications prior to visit.

SCREENSHOT 2

Lipitor is ordered during the encounter. To see just the ordered medications for this encounter (and exclude any patient reported medications), use **encmedsexclpr**.



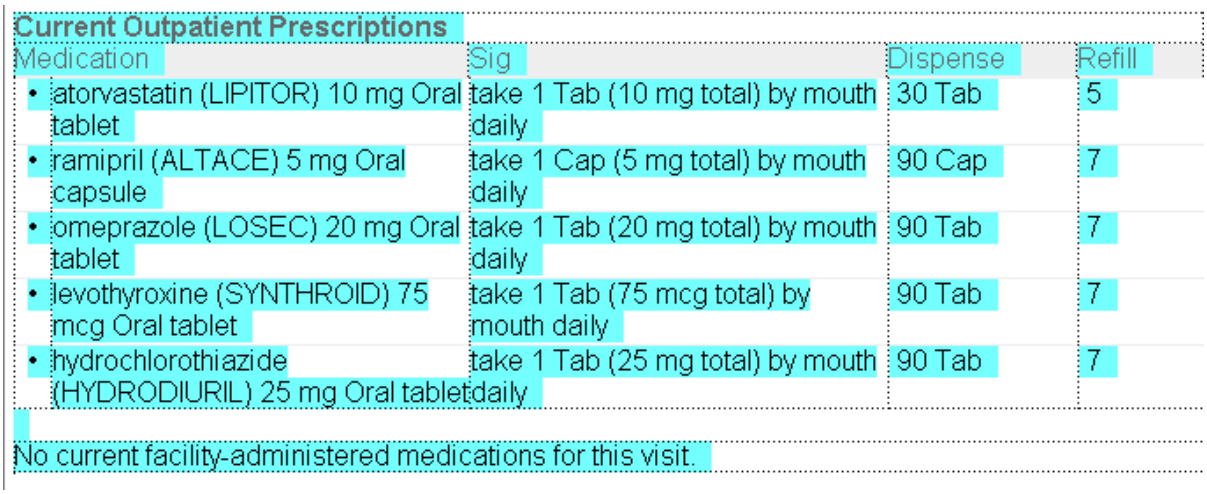
Orders Placed This Encounter

Medications

- atorvastatin (LIPITOR) 10 mg Oral tablet
  - Sig: take 1 Tab (10 mg total) by mouth daily
  - Dispense: 30 Tab
  - Refill: 5

SCREENSHOT 3

To see the updated current medication list by the end of the encounter, consider using **cmed**.



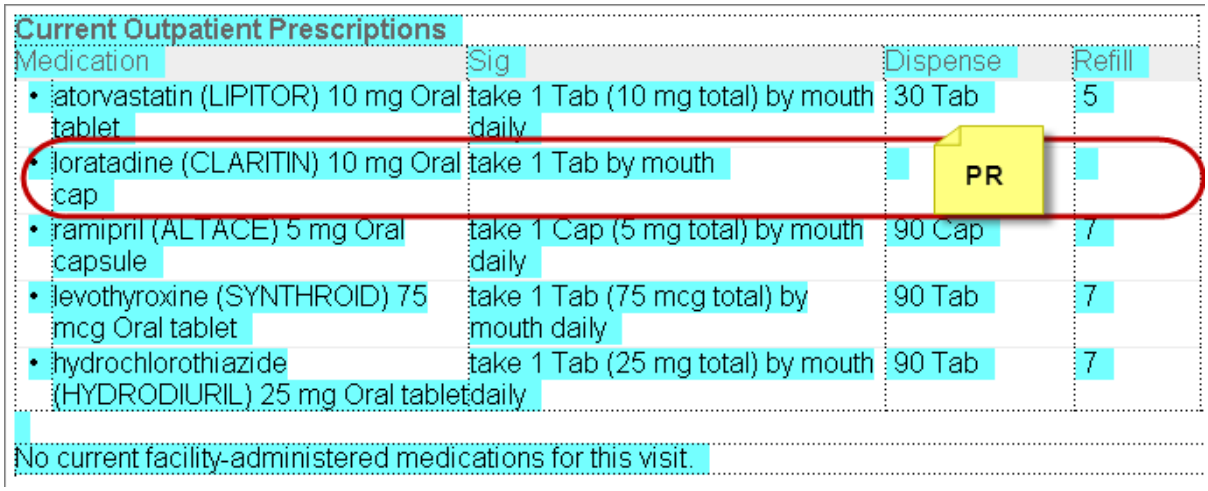
Current Outpatient Prescriptions

Medication	Sig	Dispense	Refill
• atorvastatin (LIPITOR) 10 mg Oral tablet	take 1 Tab (10 mg total) by mouth daily	30 Tab	5
• ramipril (ALTACE) 5 mg Oral capsule	take 1 Cap (5 mg total) by mouth daily	90 Cap	7
• omeprazole (LOSEC) 20 mg Oral tablet	take 1 Tab (20 mg total) by mouth daily	90 Tab	7
• levothyroxine (SYNTHROID) 75 mcg Oral tablet	take 1 Tab (75 mcg total) by mouth daily	90 Tab	7
• hydrochlorothiazide (HYDRODIURIL) 25 mg Oral tablet	take 1 Tab (25 mg total) by mouth daily	90 Tab	7

No current facility-administered medications for this visit.

SCREENSHOT 4

If Claritin was also documented as a patient reported medication and Omeprazole discontinued during the encounter then Screenshot 1 & 2 would remain the same. Screenshot 3 is replaced by Screenshot 4 as the **cmed** SmartLink now pulls in the patient reported medication but not the discontinued medication.



Current Outpatient Prescriptions

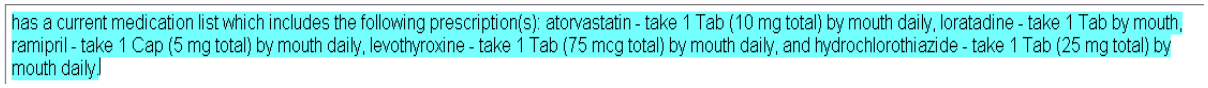
Medication	Sig	Dispense	Refill
• atorvastatin (LIPITOR) 10 mg Oral tablet	take 1 Tab (10 mg total) by mouth daily	30 Tab	5
• loratadine (CLARITIN) 10 mg Oral cap	take 1 Tab by mouth		
• ramipril (ALTACE) 5 mg Oral capsule	take 1 Cap (5 mg total) by mouth daily	90 Cap	7
• levothyroxine (SYNTHROID) 75 mcg Oral tablet	take 1 Tab (75 mcg total) by mouth daily	90 Tab	7
• hydrochlorothiazide (HYDRODIURIL) 25 mg Oral tablet	take 1 Tab (25 mg total) by mouth daily	90 Tab	7

PR

No current facility-administered medications for this visit.

SCREENSHOT 5

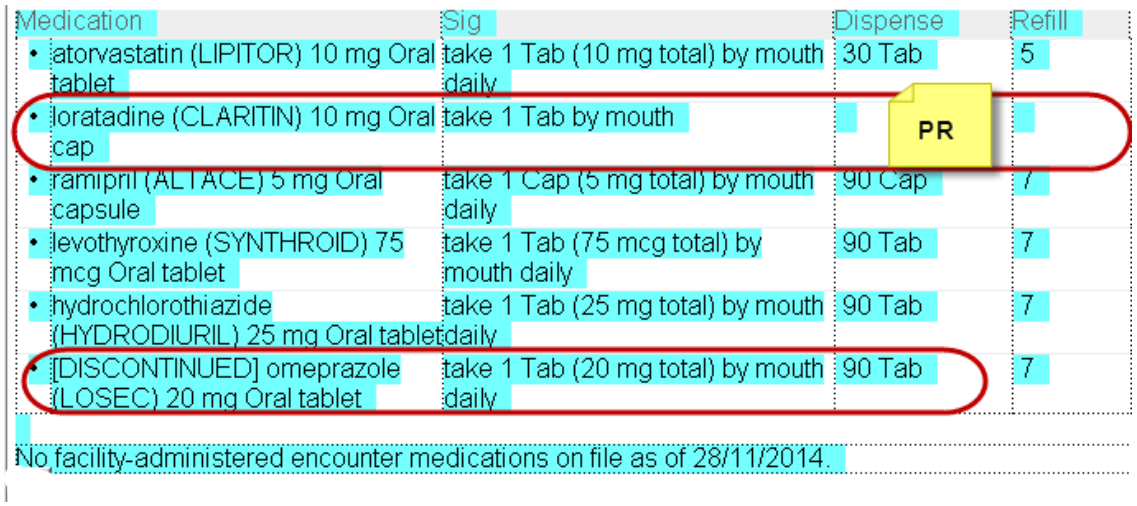
To see the updated current medication list by the end of the encounter in prose format and with the sig, consider using **cmedpwithsig**.



has a current medication list which includes the following prescription(s): atorvastatin - take 1 Tab (10 mg total) by mouth daily, loratadine - take 1 Tab by mouth, ramipril - take 1 Cap (5 mg total) by mouth daily, levothyroxine - take 1 Tab (75 mcg total) by mouth daily, and hydrochlorothiazide - take 1 Tab (25 mg total) by mouth daily.

SCREENSHOT 6

To display both the patient reported and the discontinued med at the end of the encounter, use **encmed**.



Medication	Sig	Dispense	Refill
• atorvastatin (LIPITOR) 10 mg Oral tablet	take 1 Tab (10 mg total) by mouth daily	30 Tab	5
• loratadine (CLARITIN) 10 mg Oral cap	take 1 Tab by mouth		
• ramipril (ALTACE) 5 mg Oral capsule	take 1 Cap (5 mg total) by mouth daily	90 Cap	7
• levothyroxine (SYNTHROID) 75 mcg Oral tablet	take 1 Tab (75 mcg total) by mouth daily	90 Tab	7
• hydrochlorothiazide (HYDRODIURIL) 25 mg Oral tablet	take 1 Tab (25 mg total) by mouth daily	90 Tab	7
• [DISCONTINUED] omeprazole (LOSEC) 20 mg Oral tablet	take 1 Tab (20 mg total) by mouth daily	90 Tab	7

PR

No facility-administered encounter medications on file as of 28/11/2014.

APPENDIX E: KEYBOARD SHORTCUTS FOR WINDOWS USERS

Use the following keyboard shortcuts to save time.

Use the following general keyboard shortcuts to speed up your work.	
F1	Open Help for the current activity
TAB	Move to the next field or button on the page
SHIFT+TAB	Move to the previous field or button on the page
CTRL+UP ARROW	Move up through activity tabs
CTRL+DOWN ARROW	Move down through activity tabs
CTRL+TAB	Move right through open workspaces and mini-tabs
CTRL+SHIFT+TAB	Move left through open workspaces and mini-tabs
CTRL+W	Close the selected workspace
CTRL+D	Open the More Activities menu
CTRL+G	Go to Diagnosis Entry in the Order Entry activity
CTRL+N	Go to the Visit Navigator
CTRL+ALT+S	Secure your session
CTRL+ALT+L	Log out of ***e*CLINICIAN**
ALT+F4	Close ***e*CLINICIAN**

You can also use the following standard Windows shortcuts:	
CTRL+A	Select all text
CTRL+C	Copy selected text
CTRL+X	Cut selected text
CTRL+V	Paste selected text
CTRL+Z	Undo last action, such as restore a deleted block of text or undo your selection in a SmartList
CTRL+Y	Redo the last action you undid

Use the following keyboard shortcuts to speed up your work when writing text:	
DOWN ARROW	Move your cursor to the next line of text
UP ARROW	Move your cursor to the previous line of text
CTRL+END	Move your cursor to the end of the text
CTRL+HOME	Move your cursor to the beginning of the text
END	Move your cursor to the end of the current line of text

HOME	Move your cursor to the beginning of the current line of text
CTRL+RIGHT ARROW	Move your cursor to the next word
CTRL+LEFT ARROW	Move your cursor to the previous word
SHIFT+END	Highlight from the cursor position to the end of the line
SHIFT+HOME	Highlight from the cursor position to the beginning of the line
SHIFT+DOWN ARROW	Highlight the line below the current line
SHIFT+UP ARROW	Highlight the line above the current line
SHIFT+LEFT ARROW	Highlight one character to the left of the cursor
SHIFT+RIGHT ARROW	Highlight one character to the right of the cursor
CTRL+SHIFT+RIGHT ARROW	Highlight from the cursor position to the end of the word
CTRL+SHIFT+LEFT ARROW	Highlight from the cursor position to the beginning of the word
The following mouse-based methods work for selecting text or placing your cursor within a text field:	
Click and drag your cursor to select text. To select an entire line of text, click at the beginning of the line and move your cursor down	
Double-click a word to select it	
Click anywhere within a block of text to begin writing, editing, or deleting the information in that spot	

Use the following keyboard shortcuts to move through the Visit Navigator:	
F7	Open the previous navigator section
F8	Open the next navigator section
F9	Close the navigator section
SHIFT+F7	Go to the previous navigator section without opening it
SHIFT+F8	Go to the next navigator section without opening it
ALT+UP ARROW	Move up through the table of contents. The selected section opens when you release the **ALT** key
ALT+DOWN ARROW	Move down through the table of contents. The selected section opens when you release the **ALT** key

Use the following keyboard shortcuts to navigate your In Basket:	
ALT+UP ARROW	Move up through the folder list
ALT+DOWN ARROW	Move down through the folder list
CTRL+T	Open the Out of Contact activity
CTRL+F	Forward In Basket Message

Use the following techniques to select more than one option in a list. For example, in Chart Review, you might want to select four different encounters to review.	
SHIFT+click	Select a continuous range of entries from the list. While holding down **SHIFT** on the keyboard, use your mouse to select an upper and lower bound. All entries between your two selections are highlighted. For example, use this technique to select rows 1 through 12 in a list.
CTRL+click	Select two or more individual entries from the list. While holding down **CTRL** on the keyboard, use your mouse to select each entry. For example, use this technique to select rows 1, 7, and 12 in a list. While still holding down the **CTRL** key, click an entry again to clear it.

Use the following conventions to enter dates and times relative to today:	
t	Today. Use this to indicate today's date. You can also use this as a relative date. For example, to enter today's date, type "t". For tomorrow's date, type "t+1".
w	Week. Use this for relative dates. For example, to enter the date two weeks ago, type "w-2".
m	Month. Use this for relative dates. For example, to enter the date five months from now, type "m+5".
y	Year. Use this for relative dates. For example, to enter the date one year ago, type "y-1".
n	Now. Use this to indicate the current time. You can also use this for relative times. For example, to enter the time 30 minutes from now, type "n+30".

APPENDIX F: KEYBOARD SHORTCUTS FOR MAC USERS

Additional Notes:

1. The Windows CTRL key usually performs the same function as the Mac Command and Control keys. Also note that sometimes both of the Mac keys work; sometimes only one of the two works.
2. The Windows ALT key usually performs the same function as the Mac Option or Alt key and sometimes the Mac Command key. Also note that sometimes both Mac keys work; sometimes only one of the two works.
3. If pressing any of the function keys (F1 to F12) does not cause the correct activity to occur, try pressing and holding the "fn" key when pressing the function key. For example, pressing the fn+F1 keys together should bring up the Help screen if pressing the F1 key alone did not bring it up. The Mac system preferences utility allows for changing from needing to press the "fn" key if desired.

Use the following general keyboard shortcuts to speed up your work.	
f1 or fn+f1 (see note 3 above)	Open Help for the current activity
tab	Move to the next field or button on the page
shift+tab	Move to the previous field or button on the page
control+up arrow	Move up through activity tabs
control+down arrow	Move down through activity tabs
control+tab (command+tab will allow you to cycle through to other open programs, like Windows' Alt+Tab does)	Move right through open workspaces and mini-tabs
control+shift+tab	Move left through open workspaces and mini-tabs
control or command+w	Close the selected workspace
control or command+d	Open the More Activities menu
control or command+g	Go to Diagnosis Entry in the Order Entry activity
control or command+n	Go to the Visit Navigator
command+f10 (release) then press s (see note 3)	Secure your session
command+f10 (release) then press o (see note 3)	Log out of ***e*CLINICIAN**
alt or option+f4 or command+f10 (release) then press x (see note 3)	Close ***e*CLINICIAN**

You can also use the following standard Windows shortcuts:	
control or command+a	Select all text
control or command+c	Copy selected text
control or command+x	Cut selected text
control or command+v	Paste selected text
control or command+z	Undo last action, such as restore a deleted block of text or undo your selection in a SmartList.
control or command+y	Redo the last action you undid

Use the following keyboard shortcuts to speed up your work when writing text:	
down arrow	Move your cursor to the next line of text
up arrow	Move your cursor to the previous line of text
left arrow	Move your cursor to the left one character
right arrow	Move your cursor to the right one character
fn+control+right arrow	Move your cursor to the end of all the text/page
fn+control+left arrow	Move your cursor to the beginning of all the text/page
fn+right arrow	Move your cursor to the end of the current line of text
fn+left arrow	Move your cursor to the beginning of the current line of text
control+right arrow	Move your cursor to the beginning of the next word to the right
control+left arrow	Move your cursor to the beginning of the previous word to the left
fn+shift+right arrow	Highlight from the cursor position to the end of the line
fn+shift+left arrow	Highlight from the cursor position to the beginning of the line
shift+down arrow	Highlight from the cursor position to the line below the current line at the same cursor position
shift+up arrow	Highlight from the cursor position to the line above the current line at the same cursor position
shift+left arrow	Highlight one character to the left of the cursor (or as many characters as the left arrow is pressed)
shift+right arrow	Highlight one character to the right of the cursor (or as many characters as the right arrow is pressed)
control+shift+right arrow	Highlight from the cursor position to the end of the word
control+shift+left arrow	Highlight from the cursor position to the beginning of the word

Use the following keyboard shortcuts to speed up your work when writing text:	
fn+down arrow	Move upwards (if available) through the text
fn+up arrow	Move downwards (if available) through the text

The following mouse-based methods work for selecting text or placing your cursor within a text field:
Click and drag your cursor to select text. To select an entire line of text, click at the beginning of the line and move your cursor down
Double-click a word to select it
Click anywhere within a block of text to begin writing, editing, or deleting the information in that spot

Use the following keyboard shortcuts to move through the Visit Navigator:	
F7 (see note 3)	Open the previous navigator section
F8 (see note 3)	Open the next navigator section
command+f9 (see note 3)	Close the navigator section
shift+f7 (see note 3)	Go to the previous navigator section without opening it
shift+f8 (see note 3)	Go to the next navigator section without opening it
alt+up arrow	Move up through the table of contents. The selected section opens when you release the **ALT** key
alt+down arrow	Move down through the table of contents. The selected section opens when you release the **ALT** key

Use the following keyboard shortcuts to navigate your In Basket:	
up arrow	Move up through the folder list
down arrow	Move down through the folder list
control or command+t	Open the Out of Contact activity
enter/return	Refresh or load the selected message
fn+delete	Mark the message as Done

Use the following keyboard shortcuts to select screen options using the keyboard instead of the mouse:	
command+f10 (release) then press underlined letter (see note about F keys)	Perform the action of the associated button. Often one letter of a particular button name appears underlined. If so, use that letter as the shortcut for the button. For example, in the Visit Navigator, the S in the SmartSets button is underlined. Press **ALT+S** to activate the button and search for SmartSets.

Use the following techniques to select more than one option in a list. For example, in Chart Review, you might want to select four different encounters to review.	
shift+click	Select a continuous range of entries from the list. While holding down **SHIFT** on the keyboard, use your mouse to select an upper and lower bound. All entries between your two selections are highlighted. For example, use this technique to select rows 1 through 12 in a list.
control or command+click	Select two or more individual entries from the list. While holding down **CTRL** on the keyboard, use your mouse to select each entry. For example, use this technique to select rows 1, 7, and 12 in a list. While still holding down the **CTRL** key, click an entry again to clear it.

Use the following conventions to enter dates and times relative to today:	
t	Today. Use this to indicate today's date. You can also use this as a relative date. For example, to enter today's date, type "t". For tomorrow's date, type "t+1".
w	Week. Use this for relative dates. For example, to enter the date two weeks ago, type "w-2".
m	Month. Use this for relative dates. For example, to enter the date five months from now, type "m+5".
y	Year. Use this for relative dates. For example, to enter the date one year ago, type "y-1".
n	Now. Use this to indicate the current time. You can also use this for relative times. For example, to enter the time 30 minutes from now, type "n+30".

APPENDIX G: REPORTING WORKBENCH

The Reporting Workbench component of ***e*CLINICIAN – EMR** provides you with the ability to meet disease management and preventative care goals for your patients by allowing you to quickly identify a list of patients with a specific set of criteria.

Reporting Workbench functionality in this section is:

- Accessing Reporting Workbench
- Overview of My Reports Activity
- Create and Run New Report
- Modifying Existing Report
- Working with Report Results

CONFIDENTIALITY OF INFORMATION WITHIN THE REPORTING WORKBENCH

It is the responsibility of the author of any report, regardless of the medium (printing, electronic export, etc.), to adhere to confidentiality requirements in accordance with their organization's physical safeguard policies and procedures. Transmission of confidential report data must be conducted in a secure manner with recommended disclaimers stamped on fax cover sheets, email subject lines, etc.

Report disclaimer as recommended by the ISO (Information Stewardship Office):

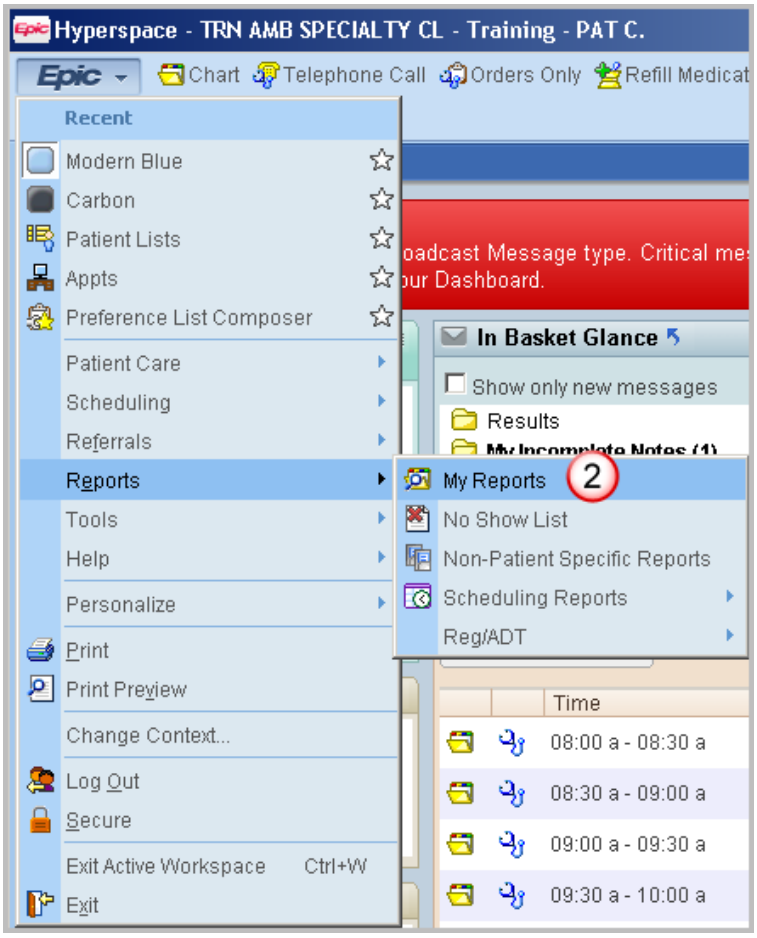
The report and any associated files are confidential and may contain personal or privileged health information as defined by Alberta's Health Information Act and is intended solely for the use of the requestor and only for the purpose stated at the time of the request. Any other use, dissemination, distribution or copy is strictly prohibited. If received in error please return to sender immediately or report to the Information Stewardship Office at 780-735-0662. Thank you for your cooperation and assistance.

All custodians and affiliates remain obligated, and are expected, to comply with their organization's overarching policy and procedure (i.e., Alberta Health Services or University of Alberta fax, email and encryption policies).

Report extracts are considered "transitory" in nature and should be confidentially shredded or deleted when their usefulness has expired. There is no legislative requirement to archive, retain or scan reports back into the EMR or the permanent legal health record.

ACCESS THE REPORTING WORKBENCH

1. Log into ***e*CLINICIAN** using your Alberta Health Services User ID and Password.
2. From the Epic button, select Reports > My Reports**.**

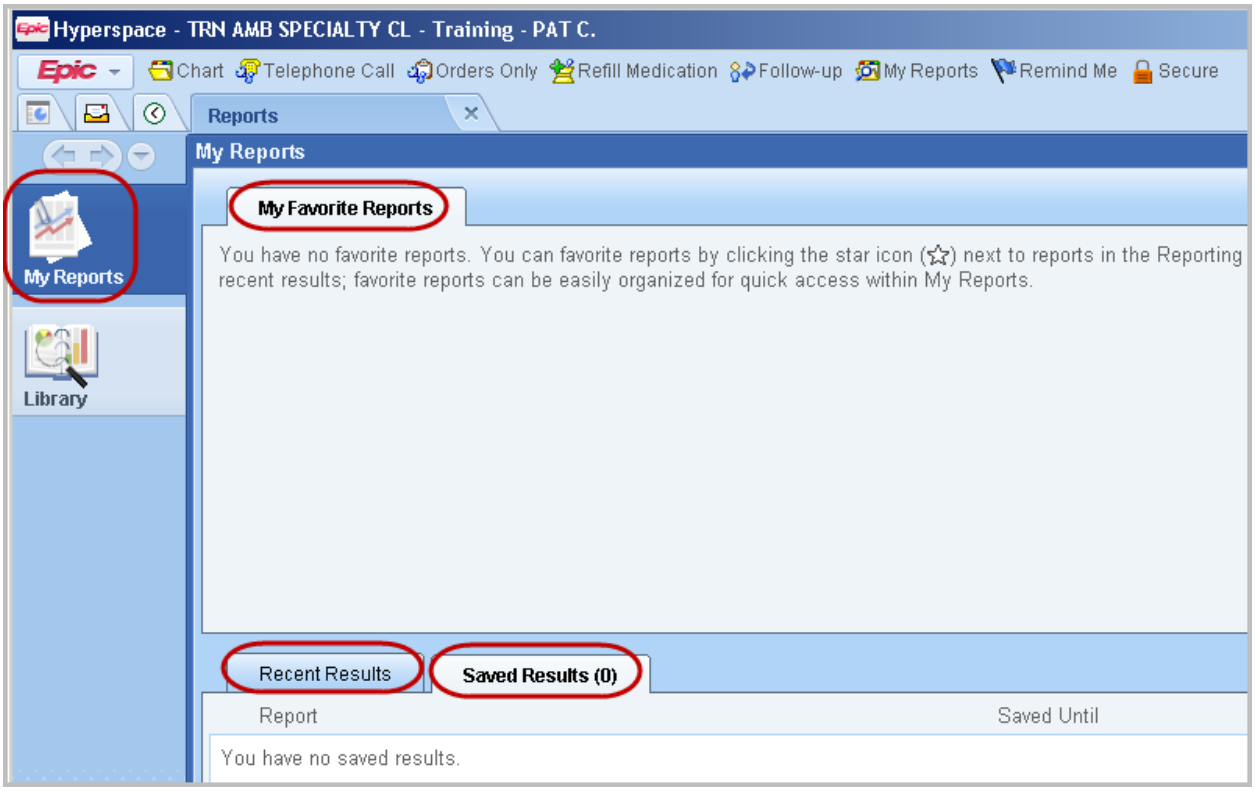


Overview of the My Reports Activity

The My Reports activity is made up of two tabs: My Reports tab and Library tab.

My Reports tab

The My Reports tab is the primary screen you see when you access the My Reports activity. You can run and access your favorite reports as well as view any recent or saved report results.

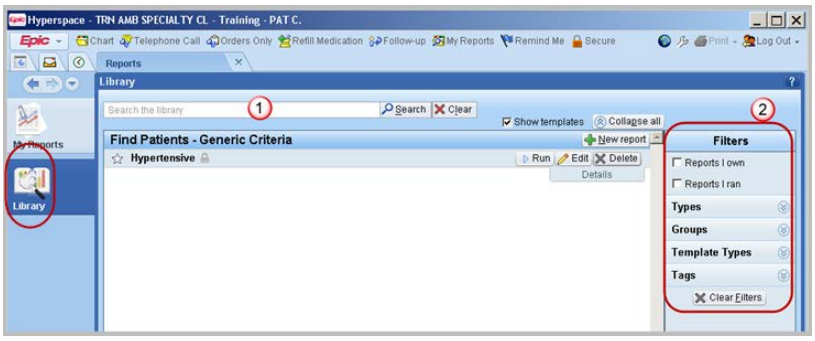


My Reports is made up of the following sections:

- My Favorite Reports: Lists all reports you marked as your favorites or were published to you as a favorite.
- Saved Results: When you view the results of a report, you have an option to save the results. When you save the results, they display in this section for future access.
- Recent Results: When you run a report from the Library or from your Favorites section, the results of that report display in this area.

LIBRARY TAB

Using the Library, you can locate and run any saved reports as well as create new reports. By default, all reports that you have access to will be shown.



1. Use the search field to find a specific report.
2. Apply filters to browse for reports that meet certain criteria.
    - Reports I Own: Lists all reports that you have created or reports that you are listed as an owner on.
    - Reports I Ran: Lists all reports you ran recently.
    - Type: Filters reports by type.
    - Groups: Filters reports by user groups.
    - Template: Lists all the current report templates available for the report type. This filter will not be used much as there is currently only one report type, “Find Patients Generic Criteria”. Please note more templates may be added in the future. The “Find Patients Generic Criteria” template should meet all of your current requirements as it is general in nature and includes all selection criteria that are available. Templates determine what search criteria are available to use in a report as well as settings for formatting the report results.
    - Tags: Tags can be added to reports when they are created. The Tags filter will allow you to find all reports that contain a particular Tag.

CREATE A NEW REPORT

You can create your own reports to quickly find all your patients that meet certain criteria. Report results can be reviewed, printed or exported to a patient list. There are two types of reports that can be created:

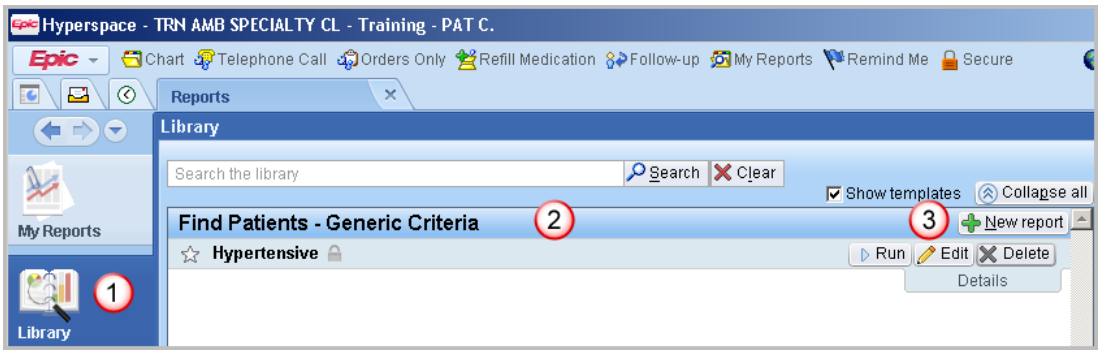
- Private reports: Only visible to the user who created them.
- Public reports: Visible to everyone who has security to see the template used to generate the report. Public reports are created by Report Administrators and are used as a means to distribute reports across the enterprises that are deemed important for patient care.

To create a report, you need to consider four items:

- Search Criteria: Used to identify which patients to include on the report. Search criteria are defined by you.
- Appearance: Controls how the report is displayed in ***e*CLINICIAN**. Appearance can be set by the report template or defined by you.
- Print Layout: Controls how the report is printed. Print layout can be copied from the report template or defined by you.
- General: General settings such as report name, description and tags.

CREATE A REPORT

1. Select the Library tab.



2. Place your cursor over the heading Find Patients - Generic Criteria.
3. Click **New Report**.

The Report Settings window displays.

CRITERIA TAB

The criteria tab is where you set the search parameters that the report will use to find patients for the report. You can add multiple criteria separated by logical operators to build complex rules upon which to find clients.

1. Set the date range that you would like the report to search within.

Date Range

The date range specified here will be used only by a time-sensitive criterion. Time-sensitive criteria are identified on the criteria window by a clock icon. If there are no time-sensitive criteria included in the report, Reporting Workbench will evaluate the criteria without using the date range.

2. Choose criteria to search on. Notice that as you make your selections, the right-hand Enter Search Values changes allowing you to enter specific values for each criterion. If appropriate, change the default Patient Base selection.

Patient Base

The Patient Base section displays ***My Patients***.

My Patients are defined as patients where you are:

- The Primary Care Provider
- The Encounter Provider
- The Supervising Provider
- A member of the Care Team

You can further categorize the patients that will display on your report by changing the Patient Base selection criteria to:

- My Care Team Patients in Time Frame
- My Current Care Team Patients
- My Scheduled Patients

3. Add more criteria using Or, And, or Custom logic operators.

Logic used between criteria

You can use one of the following to change the logic used between multiple criteria in a report:

And = The result must match ***all*** of the values for the criterion. This is the default option.

Or = The result must match ***one*** of the values for the criterion.

Custom = This option allows you to define your own logic among criteria values.

4. In the Enter Search Values section, add the details about the criteria that you have chosen. For example, if you chose Current medications you need to choose a specific medication.
5. Add multiple items within one criterion by using Or, And, or logic.

Logic used between criteria

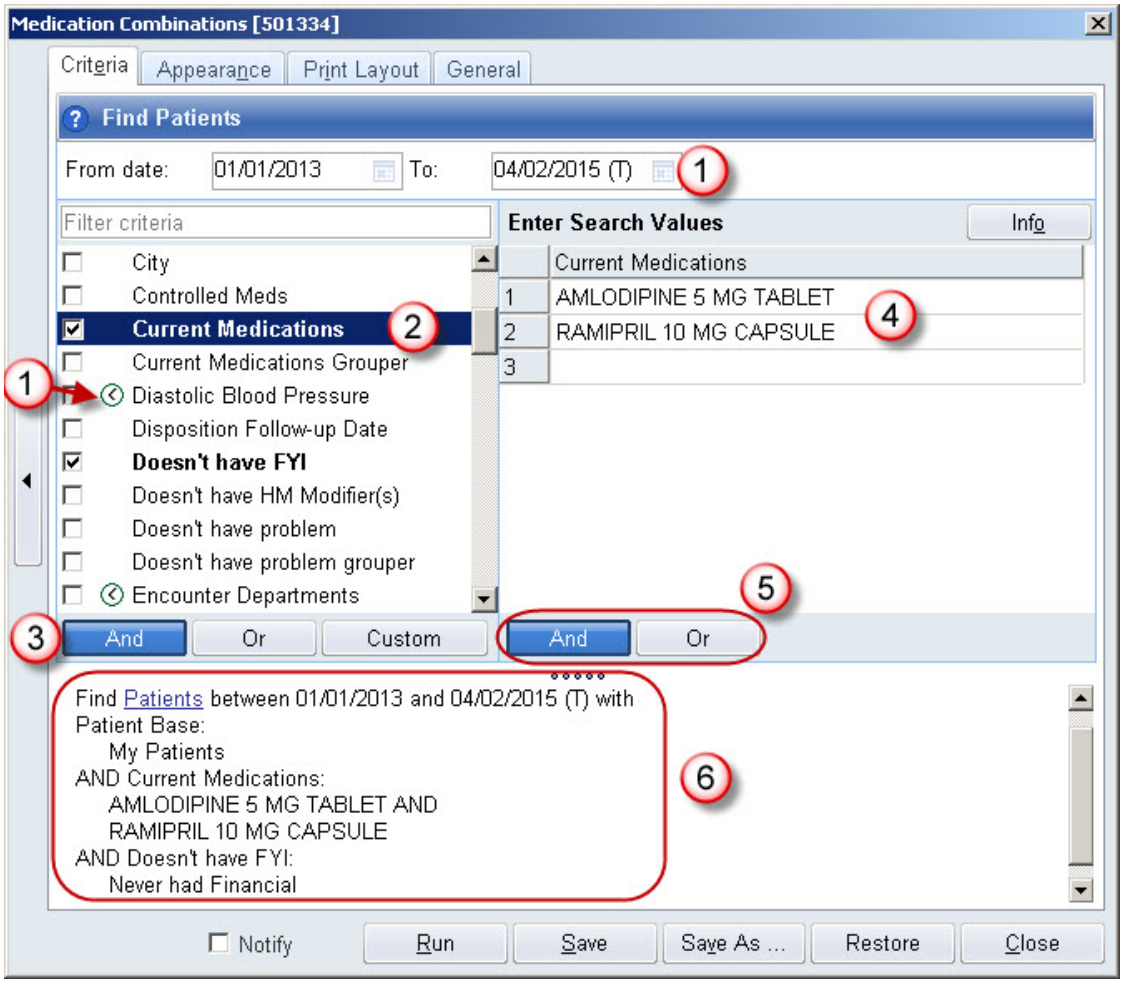
You can use one of the following to change the logic used between multiple criteria in a report:

And = The result must match ***all*** of the values for the criterion. This is the default option.

Or = The result must match ***one*** of the values for the criterion.

Custom = This option allows you to define your own logic among criteria values.

6. The search that you have created is written at the bottom of the screen.



APPEARANCE TAB

The default appearance of the report is set by the report template type. To change the appearance of a report:

1. Uncheck Use theme colors.
2. From the Property: drop down menu, select the property's appearance to set.
3. Choose a font and size.
4. Click **Set** to set the color.

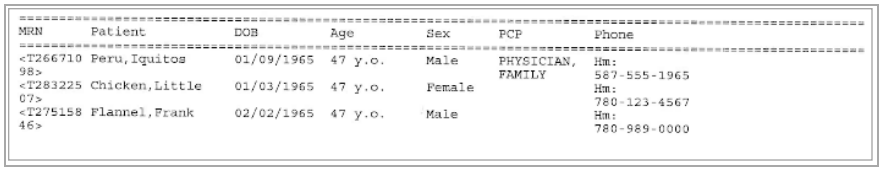
PRINT LAYOUT TAB

You must set up the print layout of your report if you will need to print it. If you run the report without the Print Layout information you will ***not*** be able to print the report.

There are two types of print layouts to choose from: Plain Text or Rich Text.

- Plain Text will print as follows (no header; footer contains printed date/time and page number):

Report records - Landscape:



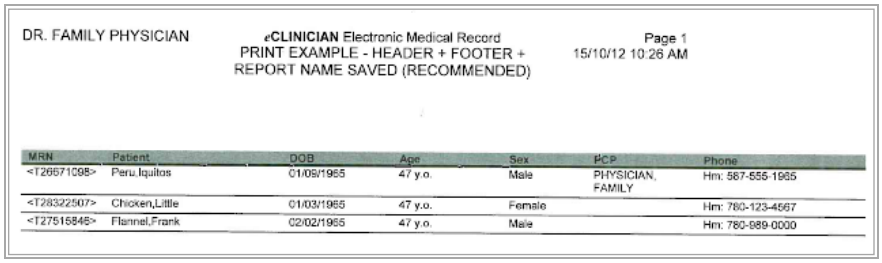
MRN	Patient	DOB	Age	Sex	PCP	Phone
<T266710 98>	Peru,Iquitos	01/09/1965	47 y.o.	Male	PHYSICIAN, FAMILY	Hm: 587-555-1965
<T283225 07>	Chicken,Little	01/03/1965	47 y.o.	Female		Hm: 780-123-4567
<T275158 46>	Flannel,Frank	02/02/1965	47 y.o.	Male		Hm: 780-989-0000

Footer:

Printed 27/9/2012, at 11:15 AM. Page 1

- Rich Text will print as follows ***(Recommended)*****:** This is how your report will print if you select the AHS header and footer and ***save*** a Report name on the General tab.

Header + report records – Landscape:



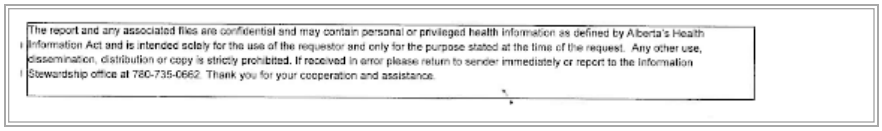
DR. FAMILY PHYSICIAN

eCLINICIAN Electronic Medical Record
PRINT EXAMPLE - HEADER + FOOTER +
REPORT NAME SAVED (RECOMMENDED)

Page 1
15/10/12 10:26 AM

MRN	Patient	DOB	Age	Sex	PCP	Phone
<T26671098>	Peru,Iquitos	01/09/1965	47 y.o.	Male	PHYSICIAN, FAMILY	Hm: 587-555-1965
<T28322507>	Chicken,Little	01/03/1965	47 y.o.	Female		Hm: 780-123-4567
<T27515846>	Flannel,Frank	02/02/1965	47 y.o.	Male		Hm: 780-989-0000

Footer:



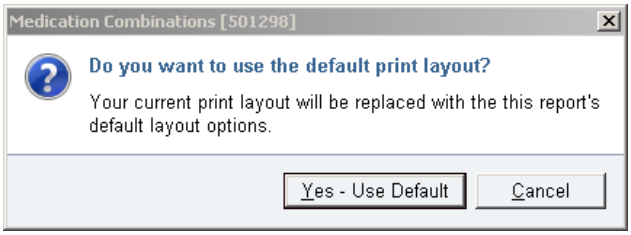
The report and any associated files are confidential and may contain personal or privileged health information as defined by Alberta's Health Information Act and is intended solely for the use of the requestor and only for the purpose stated at the time of the request. Any other use, dissemination, distribution or copy is strictly prohibited. If received in error please return to sender immediately or report to the Information Stewardship office at 780-735-0662. Thank you for your cooperation and assistance.

RICH TEXT FORMAT PRINTING (RECOMMENDED):

1. Click on the **Landscape** check box (this will include all of the seven columns on one line).
2. Click on the **radio** button next to Rich text layout.

It is strongly recommended that you use the Rich Text format and include the AHS Header and Footer. This will automatically include the disclaimers and allow you to adhere to the confidentiality requirements.

3. Click on the **Default Layout** button.


Medication Combinations [501298]
Do you want to use the default print layout?
Your current print layout will be replaced with the this report's default layout options.
Yes - Use Default
Cancel

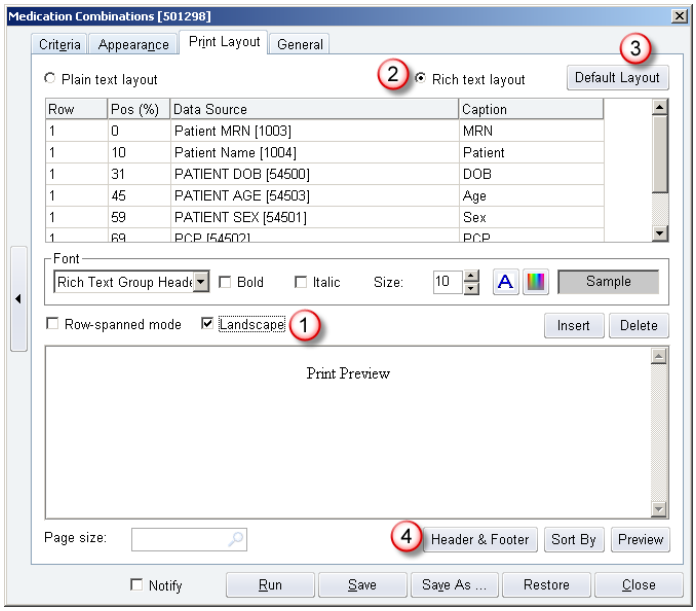
All of the report fields are filled in automatically.

Columns displayed on the report:

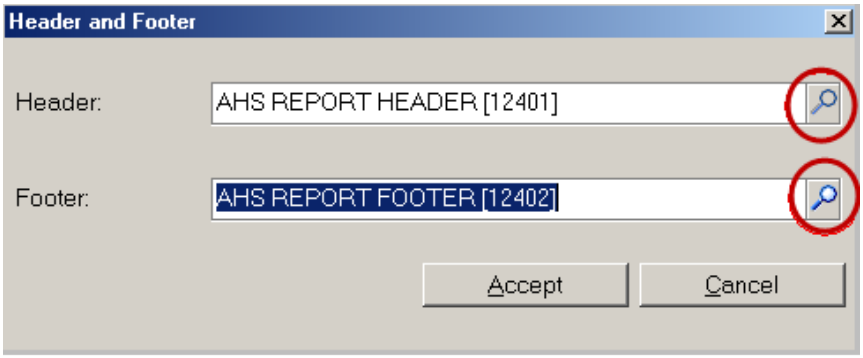
- MRN = Patient MRN – The patient's medical record number
- Patient = Patient Name – The patient's name
- DOB = Patient DOB – The patient's date of birth
- Age = Patient Age – The patient's age
- Sex = Patient Sex – The patient's sex
- PCP = Patient PCP – The patient's primary care provider
- Phone = Phone Number – All of the patient's phone numbers that are recorded in ***e*CLINICIAN**.

MRN	Patient	DOB	Age	Sex	PCP	Phone
<T2610908	Maple,Molly	21/05/1955	57 y.o.	Female		Hm: 780-412-3214 Wk: 780-333-3333
<T2664643	Maid,Brides	01/05/1963	49 y.o.	Female		Hm: 780-230-6532
<T2664653	Top,Cake	04/04/1952	60 y.o.	Male		Hm: 780-986-8523 Wk: 780-204-5819

4. Click on the **Header & Footer** button.



5. Click on the **Selection Tool** for Header and select the AHS Report Header [12401].
6. Click on the **Selection Tool** for Footer and select the AHS Report Footer [12402].



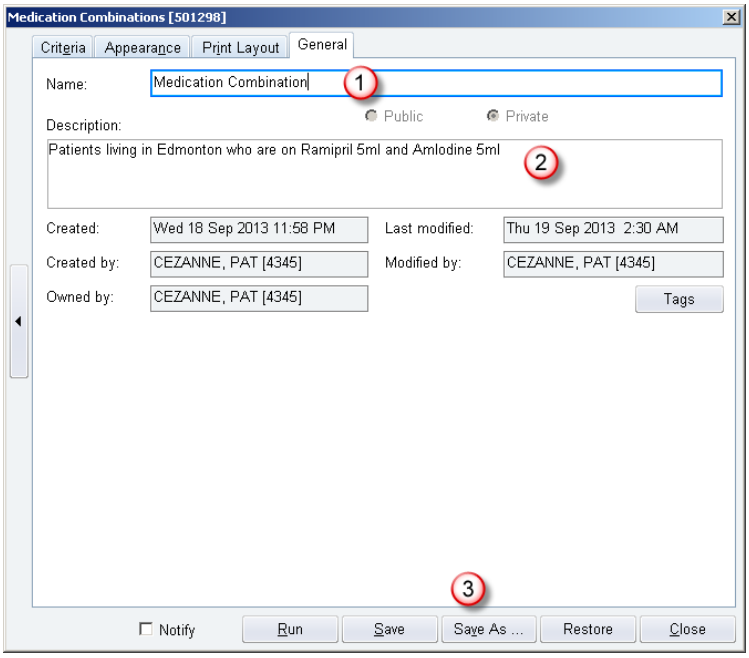
7. Click **Accept**.

GENERAL TAB

1. Type a name for your new report.

If you have set up the report to print and would like the name of the report to appear at the top of the printed report; you must enter a report name and click **Save**.

2. Type a description of the report.
3. Click one of the following buttons:
   - **Run:** Run the report
   - **Save**: Save the report
   - **Save As**: Saves the reports (and any changes) under a new report name
   - **Restore**: Restore to the templates default settings
   - **Close**: Close the report without saving your changes



You can quickly mark your saved report as a ***favorite***.

- Access the Library tab, select your report and click **Add to Favorites.**

RUN A REPORT

1. To run a report, perform one of the following:
   - Click **New Report** button and click **Run** from the Reports Setting window.
   - To run a saved report, access the Library section, search for the report, hover your mouse over the report and click **Run**.
2. To view the status of your submitted report, select the My Reports tab.
3. View your submitted report in the Recent Results section. The report has an initial status of Running.
4. As the report continues to run, you will see updates given in the Status field.
5. When the status of the report changes to Ready to view, select the report and click **View** or double-click the report.

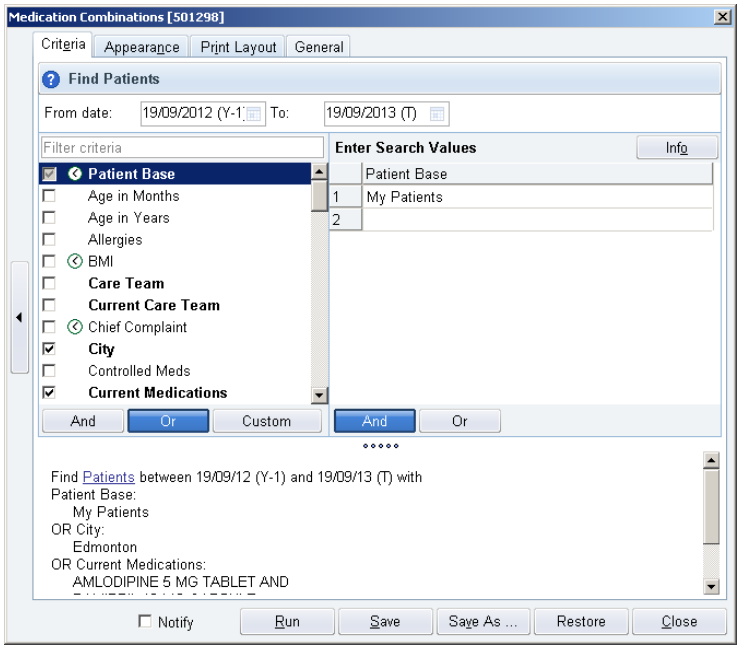
Limitations of the Reporting Workbench

- To minimize any risks to the live system (PRD), the Reporting Workbench runs on an alternate server. If, for some reason, this server becomes unavailable, an In Basket message will be sent to all users advising that Reporting Workbench is currently unavailable.
- Submitted reports are queued for processing. The Report queue will run only ***five*** reports at a time. A report status of "***Waiting to Run***" will display if there are more than five reports ahead of yours in the queue.
- The maximum records that can be returned for a given report is 5,000. Care should be taken in planning the amount of data that any one request may return.

MODIFY AN EXISTING REPORT

You can make changes to an existing report and save the changes. You can also make changes to an existing report and save the new version using a new name. In the latter case, the original report remains unchanged.

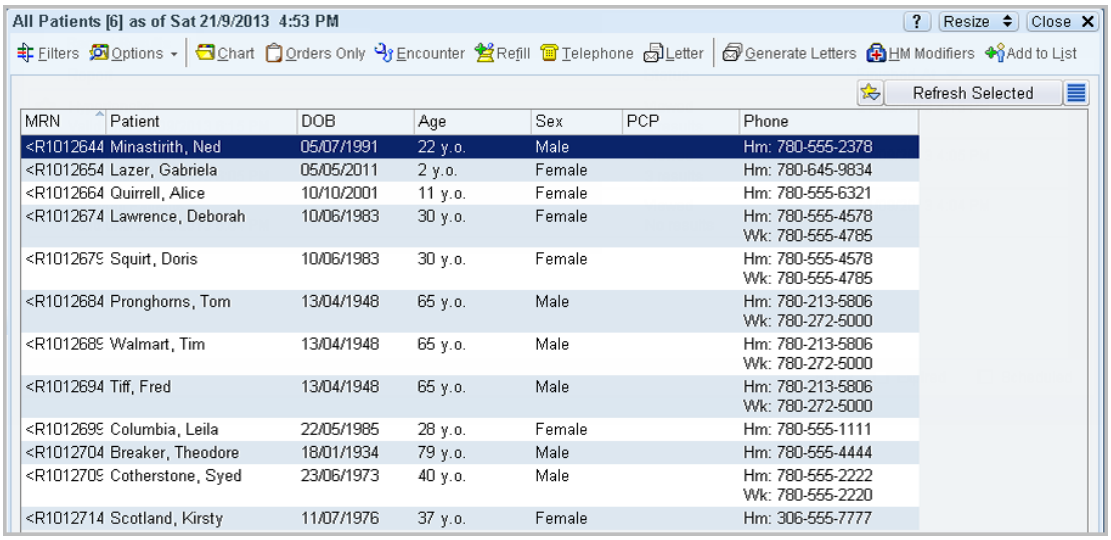
1. From the Library tab, select the appropriate report.
2. Click **Edit**.



3. Modify the appropriate report settings.
4. Perform one of the following:
   - To save the changes to your existing report, click **Save**.
   - To save the changes as a new report, click **Save As**. At the prompt, type a new name for the report and click **OK**.
5. Click **Close**.

WORK WITH REPORT RESULTS

Each row of a report represents one patient that meets the report's criteria. Each column displays one piece of information about that patient.



MRN	Patient	DOB	Age	Sex	PCP	Phone
<R1012644	Minastirith, Ned	05/07/1991	22 y.o.	Male		Hm: 780-555-2378
<R1012654	Lazer, Gabriela	05/05/2011	2 y.o.	Female		Hm: 780-645-9834
<R1012664	Quirrell, Alice	10/10/2001	11 y.o.	Female		Hm: 780-555-6321
<R1012674	Lawrence, Deborah	10/06/1983	30 y.o.	Female		Hm: 780-555-4578 Wk: 780-555-4785
<R1012679	Squirt, Doris	10/06/1983	30 y.o.	Female		Hm: 780-555-4578 Wk: 780-555-4785
<R1012684	Pronghorns, Tom	13/04/1948	65 y.o.	Male		Hm: 780-213-5806 Wk: 780-272-5000
<R1012689	Walmart, Tim	13/04/1948	65 y.o.	Male		Hm: 780-213-5806 Wk: 780-272-5000
<R1012694	Tiff, Fred	13/04/1948	65 y.o.	Male		Hm: 780-213-5806 Wk: 780-272-5000
<R1012699	Columbia, Leila	22/05/1985	28 y.o.	Female		Hm: 780-555-1111
<R1012704	Breaker, Theodore	18/01/1934	79 y.o.	Male		Hm: 780-555-4444
<R1012709	Cotherstone, Syed	23/06/1973	40 y.o.	Male		Hm: 780-555-2222 Wk: 780-555-2220
<R1012714	Scotland, Kirsty	11/07/1976	37 y.o.	Female		Hm: 306-555-7777

When you open the report you may see that not all of the results have been loaded. You can load the rest of the records by either clicking the **Load All** button or by scrolling to view the remaining results. By clicking **Load All**, all of your records are loaded into the report at once. By scrolling down, 100 records are returned at a time as you scroll.

SORT RESULTS

1. To do a simple sort of your report results, click the header of the column that you want to sort. Click the column header again to reverse the sorting of the results.
2. For a more complex sort, right-click one of the column headers to bring up the menu of sorting options.
    - Choose the Custom option to open the Custom Sort window.
    - Using this window, you can sort the report by up to three columns in either ascending or descending order.

Sorted columns display a ^ symbol with associated number to show the order of the sort. These point in the direction of the sort. In the above screenshot, the report is sorted in ascending order by MRN.

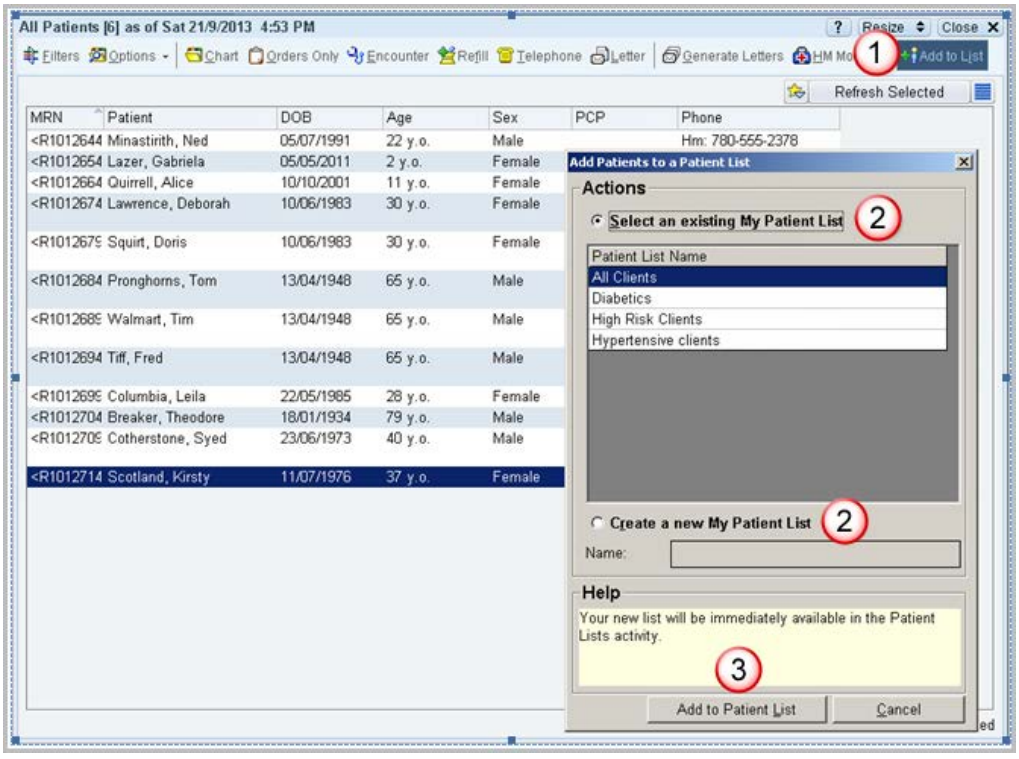
Filter Results

1. To filter your results by information in a specific column or columns, click **Filters** on the toolbar.
2. Select one or multiple columns to filter and specify values for each.
3. Once you have specified your filter criteria, click **Apply** to filter your results.
4. To look at the full report again, click the **Clear All** button and the filters will be removed.
5. To remove the filters pane from the current view either click **Filters** at the top of the workspace or press Alt-F.

Create Patient Lists from Results

You can create a patient list from your report results.

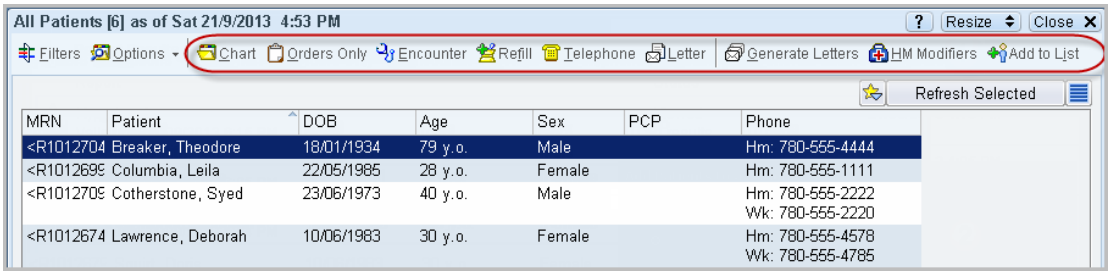
1. To create a patient list, click **Add to List** from the Reports viewer toolbar.
2. From the Add Patients to a Patient List window, either add the information to one of your displayed patient lists or click the option to create a new list.
3. Click **Add to Patient List**.



USE RESULTS TO CONTACT PATIENTS

You can take direct action from the results of a Reporting Workbench report. The actions you can take are determined by the combination of your general ***e*CLINICIAN** permissions as well as your Reporting Workbench permissions. For example, if you do not have permission to create Telephone encounters, you will not be able to perform this action from the Reporting Workbench.

The actions that you can take on the patient records displayed in your report are shown on the report toolbar:

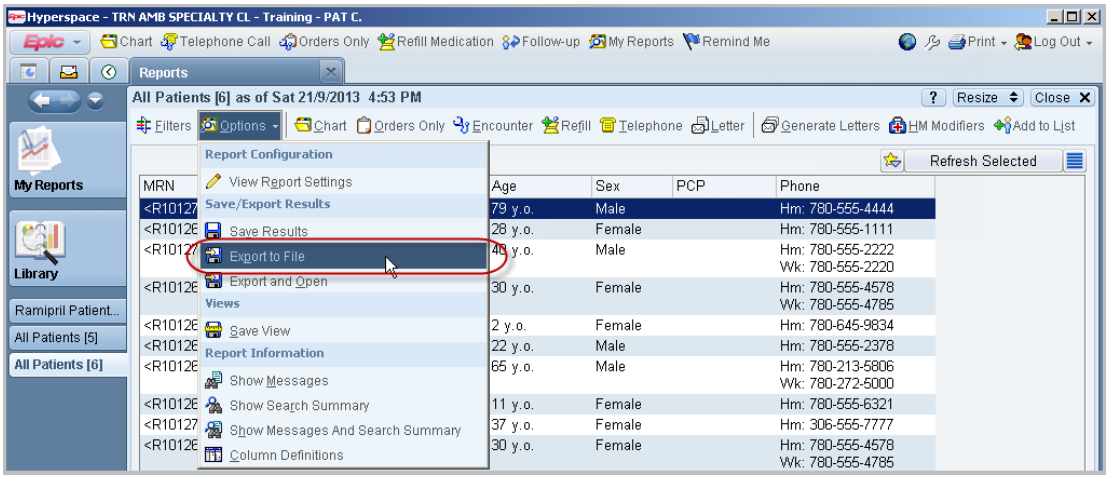


To perform any of these actions, click on the patient record in the report and then click on the **Action** button on the toolbar.

EXPORT RESULTS

Results can be exported as a .csv (comma delimited) or .tsv (tab delimited) file and imported into Microsoft Excel or another tool to display the date in another program.

1. Run the report.

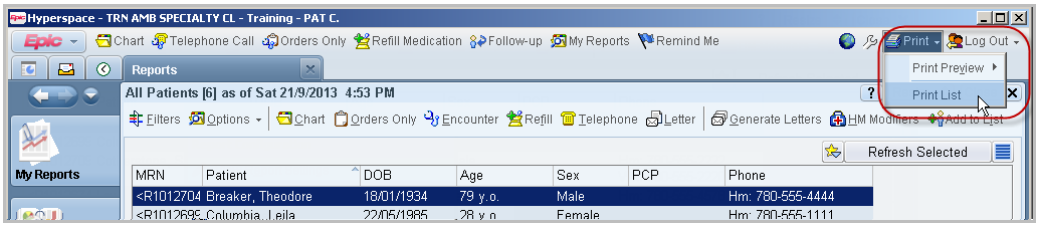


2. From the Report viewer, select Options > Export to File or Export and Open. Both selections export your results to a file. Export and Open opens the file after exporting so that you can quickly see the file you have created.
3. From the Save As pop-up window, select the location for the exported file.

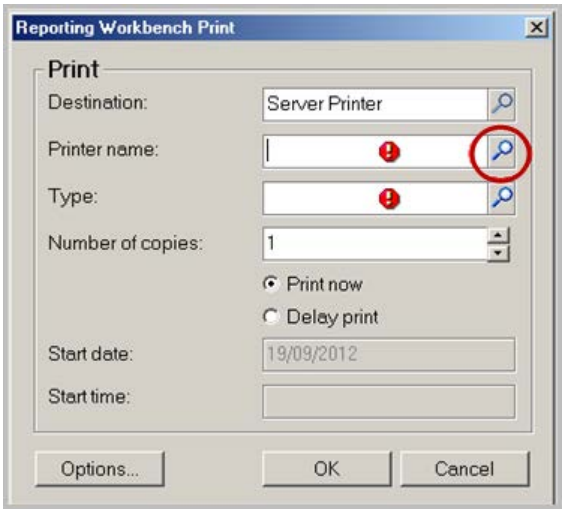
4. In the File name field, type the name of the file.
5. In the Save as type field, select the appropriate file type .csv (comma delimited) or .tsv (tab delimited).
6. Click **Save**.

PRINT RESULTS

1. At the top right corner select Print > Print List



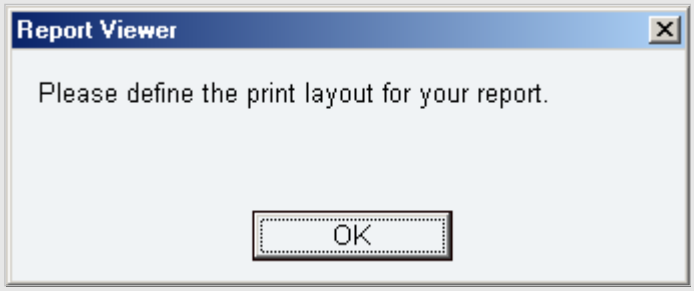
The following screen displays.



In the Destination field, you have the option of printing to a file. This option should not be used with RWB as the destination is inaccessible.

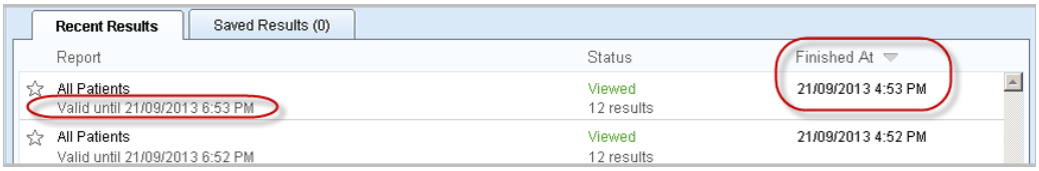
2. Click on the **Record Select** Button for Printer Name and select the printer you would like to print to from the list. The Type will be automatically filled in when you select your printer.
3. Click **OK** to print.

If you did not set up the Print Layout tab when you created the report; you will get the following message and will be unable to print the report. Refer to the Create a New Report > Print Layout Tab section on how to set up the report for printing.

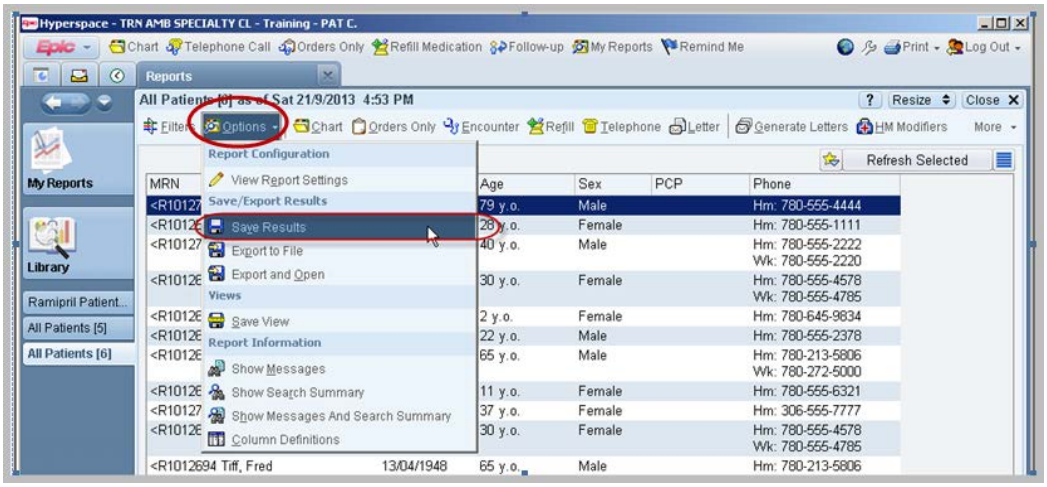


SAVE RESULTS

By default when you run a report the results are saved for two hours.



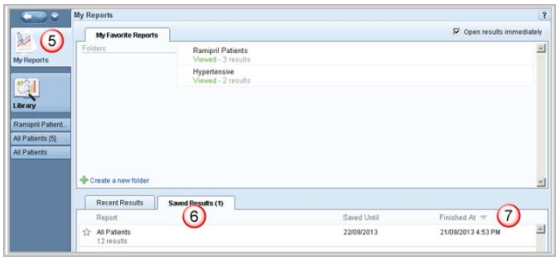
1. To save the results for review at a later time, from the Report Viewer click **Options**.
2. Select Save Results.



3. From the Save Results pop-up window, if appropriate, type a new name for report and set an expiration date.

When you choose to save the results of a report run you choose an expiration date. This is the date you potentially want to save the results until. When you open the My Reports tab, ***e*CLINICIAN** notifies you if there are saved results that are past their expiration date. It offers you the choice to either keep the saved results for longer or delete them.

4. Click **Accept**.
5. Return to the My Reports tab.
6. View your saved results in the Saved Results section.
7. The expiration date for each saved report is shown.



Saving results saves only the actual result data, not any formatting. If you want to save formatting, you can Save the report so that it can be run again. All of the changes that are discussed in the Create a New Report section would not be saved and you would have to redo all of your changes if you wanted to run the report again.